

PERINATAL LOSS & INFANT CUSTODY LOSS:  
TWO UNRECOGNIZED FORMS OF LOSS  
DURING THE PERINATAL PERIOD

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### **Abstract**

Perinatal loss and infant custody loss are two very different, yet in some ways similar loss events. The most dominant theme noted across the literature is that women and their families' experiences of perinatal loss and custody loss are socially under-acknowledged and inadequately supported by professionals. Another common thread is that both are historically oppressed experiences that uniquely impact the lives of women. The goal of this practicum report is to provide a synthesis of my learning and practice experience during my advanced practicum as it relates to providing supportive bereavement interventions to women and families who have suffered a perinatal loss or infant custody loss. Data sources for the development of this report included several books; multidisciplinary and social work databases; government, social service agency, and non-profit organizations' websites; as well as my practicum experience. The practicum setting was the Paediatric and Obstetric departments, as well as the Neonatal Intensive Care Unit of Orillia Soldiers' Memorial Hospital. A discussion of the themes that emerged from my advanced practicum experience will help to demonstrate the advancement of my knowledge and skill in working with loss and bereavement as it relates to the perinatal period. Social workers, especially those in hospital settings are in an ideal position to become actively involved in reaching out to women and their families after the loss of a baby. Thus, there is a call for feminist-minded social workers to bring awareness to the experience and service needs of women and their families who have suffered these unfortunate loss events.



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## Chapter 1 - Introduction

We lose not only through death but by leaving and being left, by changing and letting go and moving on. And our losses include not only our separations and departures from those we love, but our conscious and unconscious losses of romantic dreams, impossible expectations, illusions of freedom and power, illusions of safety, and the loss of our own younger self, the self that thought it always would be unwrinkled and invulnerable and immortal (Zeman, 2005, p. 21).

This paper explores loss and bereavement and aims to promote a more inclusive understanding of, and more open approach to, dealing with our own and others' experience of these processes. To begin, I will define the terms loss, bereavement, grief, and mourning for the context of this paper. Loss is described as a feeling of emotional deprivation (Zeman, 2005).

Loss is a universal experience affecting every individual to some degree (Price, 2008).

Importantly, it is a personal experience having a unique meaning in each individual's life. Loss comes in many forms including the loss of a person, an object, an experience, or an event (Betz & Thorngren, 2006). While the terms are often used interchangeably, bereavement refers to the state of loss, and grief is the process of experiencing reactions to loss. Lastly, mourning is the socially or culturally defined behavioural display/expressions of grief (Van, 2001).

Despite my nursing and social work education and training, when working with individuals facing imminent loss or suffering from a tremendous loss, I often felt uncomfortable and ill-prepared to support and comfort them through their loss experiences. I did not know what to say, what not to say, or what to do, and not to do. Most people, including many helping and health professionals are afraid of loss and whenever possible will avoid dealing with grief (Ilse, 1996). I, however, no longer wanted to be reluctant to deal with loss and bereavement. Instead, I



had a strong desire to better understand loss and bereavement and wanted to learn how to better support people through the grief process. Furthermore, in the event of tragedy and loss, I find there is a personal reward for being present with people in need of support from others. For this reason, I decided to make loss and bereavement the focus of my advanced practicum research.

I had the opportunity to complete my advanced practicum within the Maternal, Child & Youth program at the Orillia Soldiers' Memorial Hospital (OSMH). As a Laurentian University MSW student, I provided services to families on the Paediatric and Obstetric department, as well as the Neonatal Intensive Care Unit (NICU). The majority of my advanced practicum experience took place on the obstetric department and within the NICU where I worked with families experiencing a variety of pregnancy and birth-related complications and issues; these included but were not limited to, prematurity, infants born with anomalies (i.e., down syndrome), perinatal loss, adoption, teenage pregnancy, addiction issues, postpartum depression among other mental health concerns, single parenthood, domestic violence, and child protection issues.

The goal of this advanced practicum research report is to provide a synthesis of my learning and practice experience during my advanced practicum as it relates to loss and bereavement specific to the perinatal period. It is important to note that this report is predominately reflective of white, Western beliefs and values. This report will first provide a literature review on perinatal loss and infant custody loss then proceed with a chapter describing the process of the practicum. Next, a discussion of the themes that emerged from my advanced practicum experience will help to demonstrate the advancement of my knowledge and skill in working with loss and bereavement. Lastly, this report will conclude with implications for social work.



## Chapter 2 – Literature Review

The purpose of this literature review is to provide a synthesis of current qualitative, quantitative, and theoretical research exploring perinatal loss and infant custody loss. The most dominant theme noted across the perinatal loss literature is that women and their families continue to be underserved following a perinatal loss event. Women often report feeling disappointed, isolated, and silenced by helping and health care professionals (Cacciatore, 2009b, 2010; Cacciatore & Bushfield, 2007; Cosgrove, 2004; Gold, 2007; Kohn, Moffitt & Wilkins, 2000; Layne, 2006; Malacrida, 1999; Pector, 2004; Price, 2008; Stratton & Lloyd, 2008). Furthermore, women's grief and pain following a perinatal loss has been pathologized, marginalized and restricted (Cacciatore, 2009b). Likewise, a consistent experience reported by mothers who lose custody of their child is they do not receive acknowledgment for their loss or emotional support from professionals (Kenny & Druker, 2011; McKegney, 2003; Novac, Paradis, Brown & Morton, 2006; Raskin, 1992). The common thread between perinatal loss and child custody loss is they are historically oppressed experiences that uniquely impact the lives of women. Thus, a feminist understanding of, and approach to, these sensitive loss events is well suited (Cacciatore, 2009b; Cosgrove, 2004; Kenny & Druker, 2011; Layne, 2003). Through this review of the literature my aim is to bring awareness and understanding to these difficult loss experiences and enhance my knowledge on how to provide supportive bereavement interventions to women and their families who have suffered these unfortunate loss events.

Several books and multidisciplinary databases were utilized for this review including Ebscohost, Proquest, Ontario Scholars Portal, PsychINFO, and Social Service Abstracts. Additionally, I retrieved some of the literature from government, social service agency, and non-profit organizations' websites. The key words used to retrieve literature relevant to this topic



included combinations of the terms *perinatal loss*, *loss and bereavement*, *miscarriage*, *stillbirth*, *social work*, *feminist*, *custody loss*, *maternal bereavement*, and *child protection*. This first section of the literature review will define and provide the prevalence of perinatal loss, discuss the historical oppression of women's experience of this loss event, describe the aftermath of perinatal loss, explore social work interventions, and conclude the perinatal loss section with implications for social work research and practice. The second section of this review of the literature will discuss involuntary loss of custody in terms of this event being another unrecognized form of loss, outline reasons for infant custody loss, describe the loss experience, as well as the aftermath, and conclude by examining the social worker's role in providing bereavement support following this particular loss event.

### **Perinatal Loss: Definitions and Prevalence**

What is a miscarriage but an early stillbirth. A baby is a baby, and the size or gestation should not matter when it comes to the love, hopes, and dreams – along with the accompanying devastation – when the baby dies. While the losses seem small to some even invisible, in fact these unborn already have life stories in hearts of their parents (Seftel, 2006, p. 10).

Rybarik (2000) indicates that perinatal loss in its broadest sense includes all losses from the time of conception through to the first month of life. The focus of this section of the literature review, however, is on miscarriages and stillbirths. In the literature the terms perinatal loss, reproductive loss, fetal demise, and pregnancy loss are used interchangeably to refer to miscarriages and stillbirths. Stillbirth and miscarriage remain relatively common complications in pregnancy. It is estimated that between 25 to 50% of all pregnancies end in miscarriage or loss (Public Health Agency of Canada, 2008a). A miscarriage, also known medically as a



spontaneous abortion, is defined as the loss of a pregnancy before the fetus is viable (Cosgrove, 2004); generally before 20 weeks gestation (Cacciatore, DeFrain, Jones & Jones, 2008).

Miscarriages are the most common form of reproductive loss with 80% of them occurring in the first trimester (Cosgrove 2004). Causality of miscarriages is often unknown (Mahan & Calica, 1997).

In Canada, the standard definition of a stillbirth is the death of an unborn baby (intrauterine) or death of a baby during delivery with a gestation of 20 weeks or greater, or a birth weight of at least 500 grams (Public Health Agency of Canada, 2008a). While the stillbirth rate has decreased over the past four decades, the proportion of overall perinatal deaths due to stillbirth has increased. Stillbirths are more common than might be expected (Cacciatore, Schnebly & Froen, 2009), accounting for more than half of all perinatal deaths. The reported stillbirth rate in the industrialized world is typically under 10 per 1000 total births (Public Health Agency of Canada, 2008a). Often stillbirth occurs at or near full-term to otherwise seemingly healthy infants (Cacciatore, 2009b). Although there are several medical explanations for stillbirth such as congenital anomalies, pregnancy complications, accidents, and infections, more than 25% of stillbirths are the result of unknown causes (Public Health Agency of Canada, 2008a). Historically, minority groups have been over-represented in both fetal and infant mortality rates. The prevalence of stillbirth is difficult to accurately calculate because international definitions and data reporting vary widely (Cacciatore & Bushfield, 2007). With increasing maternal age and the use of technology to foster conception there are risks to pregnancies, thus making it more likely that social workers will encounter clients who have experienced pregnancy loss (Cosgrove, 2004).

The most significant difference between a stillbirth and a miscarriage is that, unlike with



miscarriages, stillbirths always involve the birthing process which may make the loss more tangible for some parents (Greedy, 1997). At the same time, however, after a stillbirth there are no tangible signs of parenthood to affirm the role as parents (Cacciatore et al., 2008). One of the most consistent findings in the literature is that both miscarriages and stillbirths are perceived as “invisible” deaths (Cosgrove, 2004). Both of these experiences lack legitimization as losses to be mourned and the impact of such losses on women and their families is underestimated, especially when compared to the loss of a live-born child (Cacciatore et al., 2009; Stratton & Lloyd, 2008). Across the perinatal loss literature, the concept of “disenfranchised grief” appears time and time again (Cacciatore, 2009; Cacciatore et al., 2008; Cosgrove, 2004; Price 2008). Kenneth Doka (as cited in Kenny & Druker, 2011; McKegney, 2006) has provided great insight into the concept of disenfranchised grief which recognizes that there are social norms that govern how we grieve, for how long, when we grieve and for whom we should grieve for. Disenfranchised grief is experienced by those whose significant losses are deemed illegitimate by society (McKegney, 2004). Thus, families who suffer a perinatal loss are, and have historically been, disenfranchised—isolated with little opportunity to express or resolve their grief.

### **Historical Oppression of Women’s Experience of Perinatal Loss**

Rooted in a patriarchal structure, the medical model has historically dominated and oppressed women’s experience of perinatal loss. Prior to the development of bereavement protocols in the mid-1980s, women’s perinatal loss experiences were dismissed. Women who gave birth to a stillborn child were heavily sedated and separated from their babies immediately after giving birth. It was believed that women’s experiences of perinatal loss were “generally understood as best left forgotten” (Davidson, 2008, p. 280). Women’s psychosocial needs were unacknowledged by hospital staff, and they were left to grieve in isolation and silence



(Davidson, 2008). The medical model objectifies women's bodies, undermines an appreciation for their lived experience of pregnancy loss, and fails to acknowledge the degree to which such losses affect them psychologically (Cosgrove, 2004). For instance, throughout history, women's emotional responses to perinatal loss have been pathologized. Traditional empirical studies on perinatal loss ignored the psychological impact of pregnancy loss on women and reflected sexism and victim-blaming (Cosgrove, 2004). For example, Freudian theory implied that motherhood was a central goal in all women's lives. Women's identities often relied on their ability to child bear and those who did not successfully bear children were considered deviant and defective (Gerber-Epstein, Leichtentritt & Benyamini, 2009). Furthermore, the vast majority of empirical research has predominantly focused on predictors of pathological grief (Rich, 2000) and has made assumptions about the negative effects of prior loss on women's subsequent pregnancy and parenting capacities. Such research has over-emphasized problems and deficits seen in women (Cosgrove, 2004).

Dominant discourses, such as socially-constructed norms and gender role stereotypes guide women's, families' and society's perceptions and responses to perinatal loss (Abboud & Liamputtong, 2003; Price, 2008). Reagan (2003) reflects on both her personal experience of, and research on, miscarriage indicating that there are expectations placed on women dictating how they should and should not proceed through their grieving process (Cosgrove, 2004). Moreover, Layne (2003) reflects on her own experience with pregnancy loss suggesting that the social message sent to women is that pregnancy loss is a personal failure. Certainly, there is long-standing mother-blaming discourse in literature and public policy (Cosgrove, 2004; Jackson & Mannix, 2004). From the time of conception women are held responsible for their children's outcomes (Jackson & Mannix, 2004). Thus, perinatal death carries morally charged ideals about



parenting and motherhood, and consequently many mothers assume tremendous shame and guilt over the death of their baby (Malacrida, 1999). Rather than looking at the role social policy plays in women's and their unborn babies' health and wellbeing, blame is placed upon women for their children's unfavorable outcomes (Jackson & Mannix, 2004). It is evident in both health and child welfare literature that social workers have significantly contributed to mother-blaming (Jackson & Mannix, 2004), thereby perpetuating women's socially oppressed position (Payne, 2005).

Viewing perinatal loss as a personal and private tragedy rather than a public health issue deflects attention away from broader social inequalities that effect pregnancy outcomes (Reagan, 2003). Psychosocial stressors such as mental illness, low socioeconomic status and lack of social supports make this loss experience for some women that much more isolating and devastating (Cosgrove, 2004). Many social inequalities that affect pregnancy outcomes such as poverty, environmental hazards (Cosgrove, 2004) and violence against women (Layne, 2006) are underestimated and/or ignored. There is an inadequate feminist understanding of the female body, reproduction and motherhood reflected within the mainstream literature (Cosgrove, 2004; Jackson & Mannix, 2004). Furthermore, there is a lack of practice-based research and dialogue among social workers on the topic of reproductive loss (Layne 2003, 2006; Price, 2008). Layne (2003) suggests that feminists have avoided pregnancy loss because it overlaps with abortion politics.

Despite improved standards of care resulting from the development of perinatal bereavement protocols, perinatal loss often continues to be an isolating experience for women and their families. Professionals' responses to experiences of miscarriages and stillbirths have profound and long-lasting effects on parents in the aftermath of pregnancy loss (Cosgrove, 2004). For instances, bereaved parents have reported regrets as a result of not being given



appropriate options by staff, and many reported vividly remembering the way in which they were informed about their loss (Kohn et al., 2000). Gold (2007) conducted a systematic review of more than 1,100 articles from 1966 to 2006 that addressed perinatal loss. Grieving parents frequently reported that many of the professionals' responses were thoughtless and insensitive. Layne (2006) indicated that as many as 80% of women reported feeling angry about the care they received after a pregnancy loss. Participants in Malacrida's (1999) study were unhappy with the post-loss education they received. Unfortunately, the dominant medical model continues to primarily focus on the physical management of perinatal loss while underestimating women's psychosocial needs. Additionally, due to a tendency to mistakenly associate grief with the life span of the child rather than the meaning of the loss itself, there remains an underlying belief that miscarriage and stillbirth are not significant losses justifiable of mourning (Cosgrove, 2004).

Cacciatore (2010), Malacrida (1999), and Price (2008) along with numerous other researchers found that following a perinatal loss bereaved parents want, even need, so badly for their stories of loss to be acknowledged. However, discussions about death, especially the death of a child are often avoided (Cosgrove, 2004; Price, 2008), which impedes the bereavement process (Cacciatore et al., 2008). Layne (2003) suggested that acknowledging and talking about perinatal loss is taboo because it is inconsistent with the assumption that all pregnancies are supposed to have a happy ending, and it forces us "to acknowledge that we are not in control of our own fates" (p. 1889). Further contributing to this silence is a culture that holds individuals responsible for their misfortunes. Thus, reproductive loss is a socially stigmatized experience (Cosgrove, 2004; Price, 2008).

Women are further disempowered by social stigma surrounding perinatal loss when their pregnancy is the result of rape, incest or an unplanned or undesired pregnancy. Under these



circumstances some losses may never be disclosed (Price, 2008). The silence that surrounds perinatal loss events acts as a barrier to a wide range of social supports which makes this already painful experience that much harder to bear (Layne, 2003). It is this unrecognized or in other words disenfranchised grief that is likely to intensify and exacerbate women's grief responses (Van, 2001), in turn increasing their risk for complicated grief and leading to a need for therapy (Cacciatore, 2010; Malacrida, 1999). As Malacrida (1999) suggested, the pathological aspect of grief relates more to lack of social recognition and support than to the nature of the loss or the characteristics of the grieving individual.

### **Perinatal Loss: The Aftermath**

The grief from the death of a child is reported as one of the most debilitating and painful experiences (Cacciatore & Bushfield, 2007). Cacciatore (2010) is one of the few scholars who in addition to recognizing the emotional, cognitive and spiritual consequences that pregnancy, the birthing process and stillbirth have on women, discussed the physiological effects. Importantly, in order to view perinatal loss from a holistic perspective, the impact this devastating loss has on a women's body, mind, emotions and spirit must be recognized. Malacrida (1999) implied that perinatal loss may be more difficult for women in modern, Western culture. Advanced technology is said to enable the development of earlier maternal-baby bonds, and it has a tendency to portray pregnancy as a more selectable, manageable and predictable experience thereby fostering unrealistic expectations of success. The social expectation that women can control the outcomes of their pregnancies leads to viewing negative outcomes as the personal failures of women. Furthermore, similar to the reports in many other studies, women in Abboud and Liamputtong's (2003) study reported blaming themselves, specifically their bodies for their losses. Women often view their pregnancies as an extension of self; therefore some women feel a



sense of self-betrayal and grieve their perinatal loss as a loss of a part of themselves (Cacciatore et al., 2008). The loss often has negative implications on women's sense of identity, social role, self-image, sexuality, and reproductive past and future (Price, 2004).

In general, women's responses to perinatal loss include shock, blame, guilt, fear, irrational thoughts, and even feelings of temporarily going "crazy", all of which are viewed as normative responses in the aftermath of perinatal loss (Abboud & Liamputtong, 2003; Cosgrove, 2004). Additionally, women frequently report feeling disenfranchised from society and lonely (Cacciatore, 2009b), as well as a sense of unreality and depersonalization (Cacciatore et al., 2008). After these sudden and most often unexpected losses from miscarriage and stillbirth, mothers and their families are left desperately searching for answers to often inherently unanswerable questions. The loss of an expected baby affects the entire family system (Cacciatore, 2010; Malacrida, 1999). Consequently, it is not unusual to observe significant stressors in families after such a tragedy (Cacciatore, 2009b; Cacciatore et al., 2008).

Researchers found that there are definite differences between maternal and paternal grieving styles, roles and the emotional expressions after the loss of a child (Cacciatore et al., 2008; Rich, 2000). For instance, mothers typically experience higher levels of depression, yearning, anxiety, guilt, shame, and symptoms of trauma, while fathers experience more anger. The physiological aspect of pregnancy and loss are likely to account for some of the differences in mothers' and fathers' responses (Cacciatore et al., 2008). Consistent with Abboud and Liamputtong's (2003) study, Black's (1991) study concluded that after a pregnancy loss women's grief responses were more immediate, intense and longer lasting compared to their male partners. Men are socialized to dismiss their feelings, avoid expression of emotions and to be strong even after suffering a tremendous loss (Abboud & Liamputtong, 2003; Cacciatore,



2009b; Layne, 2003). However, these gender differences can be overemphasized and become stereotypes rather than reality. Furthermore, in a review of the literature on the effects of stillbirth on couples' relationships, Cacciatore et al. (2008) found that loss from stillbirth was both a crisis and an opportunity for closeness for the couples. Overall, these studies emphasized that each individual and couple has a personalized and unique grieving style.

Following the loss of a child, mothers as well as fathers can suffer a variety of physical, mental and socially adverse effects such as depression, anxiety, mental illness, suicidal ideation, family disorganization, economic deprivation, and social isolation (Cacciatore et al., 2008). Price's (2004) review of empirical literature on women's responses to reproductive loss found that elevated levels of depression, anxiety, and psychological distress have been associated with reproductive loss, particularly during the first six months post-loss. Several studies reported serious mental health issues persisting for months and even years. For years, women may continue to be overwhelmed as they struggle for a sense of regained control and normalcy in their lives (Cacciatore, 2007). The immediate weeks and months following the loss appear to pose the greatest risk for serious mental health challenges (Price, 2008). Although some women experience prolonged psychological issues and complicated grief after the loss of a baby, in most cases, temporary and situational anxiety and depressive symptoms are normative responses to perinatal loss (Friedrichs, Daly & Kavanaugh, 2000; Price, 2008).

Across the literature there fails to be consistent reports on the definition and prevalence of complicated grief among this population (Cacciatore, 2009b, 2010; Friedrichs et al., 2000; Malacrida, 1999). Furthermore, while numerous studies imply that subsequent pregnancies after perinatal loss result in maladaptive attachment, many studies show no such connection (Cacciatore, 2010). Given the circumstances, worrying about subsequent pregnancy outcomes



and the potential for future loss is also a normative response among bereaved mothers and their partners rather than a sign of psychopathology (Price, 2004). Grief responses may be influenced by individual histories, pre-existing mental illness, coping style, individual resiliency, locus of control, family cohesion, degree of attachment with the baby, social supports, perceived gender role, culture (Cacciatore et al., 2008) social support, legitimization of loss, opportunities for rituals, and existential emotions among many other factors (Cacciatore, 2010). Clearly, it is evident that the process of grief is complex and evolving, and more importantly a unique individual experience. By discussing the affective, psychological, physiological, spiritual, and social affects perinatal loss can have on women and their families it can be understood that the loss of a precious baby by miscarriage or stillbirth have an impact on every aspect of one's life. Next, this report will discuss how social workers can provide supportive bereavement interventions to women and families after suffering such a tremendous loss.

### **Social Work Interventions**

In this section of the report, I will first briefly discuss social work theory relevant to this topic, then take a more in-depth look at the social worker's role in providing perinatal loss bereavement support.

#### **Theory.**

The dominant social work theories across the literature on perinatal loss include feminist theory (Cacciatore, 2009b; Cosgrove, 2004; Layne, 2004, 2006), ecological theory (Cacciatore et al., 2008, 2009; Cosgrove, 2004; Price, 2008), crisis intervention theory (Abboud & Liamputtong, 2003; Mahan & Calica, 1997; Pauw, 1991), grief theory (Cosgrove, 2004; Mahan & Calica, 1997; Pauw, 1991; Rybarik, 2000), and attachment theory (Cacciatore & Bushfield, 2007; Price, 2004). Additionally, the perinatal loss literature emphasizes the importance of



culturally sensitive (Cacciatore, 2010; Mahan & Calica, 1997) and holistic approaches (Cacciatore et al., 2008; Davidson, 2008; Public Health Agency of Canada, 2008b).

A feminist perspective is highly relevant because pregnancy and giving birth are uniquely women's experiences (Cacciatore et al., 2008). Furthermore, a feminist lens allows for a critical examination of perinatal loss as a historically oppressed experience (Cosgrove, 2004; Price, 2008). Moreover, it offers a multi-dimensional view of pregnancy and motherhood. As Gerber-Epstein et al. (2009) pointed out, while some feminists argued that motherhood is a source of control over, and restriction of, women, other feminists regard motherhood as an important aspect of feminine identity. Despite these differences, however, all feminists would agree that women should have control over their lives and roles as mothers (Gerber-Epstein et al., 2009). Lastly, according to Cacciatore et al. (2008) feminists celebrate childbirth as a way to affirm women's uniqueness and power as a gender.

An ecological understanding of reproductive loss requires a systems perspective that recognizes that reproductive loss extends beyond individual women's experiences and affects the perceptions and responses of families, culture and society, in turn influencing maternal responses (Cacciatore et al., 2008; Price, 2008). Additionally, keeping with feminist thinking - the personal is political - it is critically important to take into account the sociopolitical and cultural context in which pregnancy loss occurs (person-in-environment) (Cosgrove, 2004; Gerber-Epstein et al., 2009).

When a family loses an expected child due to a perinatal loss they are in crisis. Individuals who experience traumatic events often benefit from rapid assessment and crisis intervention, whereby the goal is to mobilize needed support and resources (Coady & Lehmann, 2008). When a family loses a child they are in crisis. The immediacy and intensity of women's



grief responses following a perinatal loss (Abboud & Liamputtong, 2003) further supports the utilization of crisis intervention with this population.

When working with loss and bereavement it is necessary to be familiar with grief processes. Stage theorists suggest that grief progresses in stages, for example Kubler-Ross is widely known for proposing the five stages of grief: Denial, anger, bargaining, depression and acceptance. Critics of stage theories argue that grief is non-linear and more variable and individual than stage theories presume (Cacciatore et al., 2008; Cosgrove, 2004; Grout & Romanoff, 2000). Another leading grief theorist, William Worden (as cited in Kenny & Druker, 2011; Public Health Agency of Canada, 2008b) outlines the four tasks of grieving which include, to accept the reality of the loss; to work through the pain of grief; to adjust to an environment in which the lost one is missing; and to emotionally relocate and memorialize the lost one and move forward with life. Similar, to Kubler Ross's stages of grief, Worden recognized that the tasks of grief are not clearly separated or sequential. Equally important, Rybarik (2000) indicated that current grief theory holds that the bereaved do not "get over" their loss rather they integrate the loss into their lives.

Additionally, attachment theory contributes to the understanding of parent-child attachments, which in turn provides insight into bereaved parents' responses to the loss of a child (Price, 2008). This theory has been criticized for overemphasizing the importance of mother-child relationships and consequently supporting mother-blaming while insufficiently acknowledging the effects the environment has on attachments (Coady & Lehmann, 2008). Cacciatore and Bushfield (2007) pointed out that attachment is not contingent on the age of the baby, time spent with the child or interdependence. Rather, the complexities and scope of attachment must be recognized.



Certainly, perceptions and responses to perinatal loss are connected to individuals' cultural, religious, and spiritual beliefs and values. Perinatal social workers have an obligation to become familiar with the traditions of religious, cultural and ethnic groups served at their place of practice (Mahan and Calica, 1997); and to ensure that their own cultural values are not imposed onto clients (Cacciatore, 2010). Indeed, social work is familiar with, and trained in, providing culturally sensitive and holistic approaches. Despite efforts to work holistically, spiritual assessments continue to be overlooked in practice (Public Health Agency of Canada, 2008b). Likewise, Cacciatore et al.'s (2008) and Davidson's (2008) studies found that there is a need for more comprehensive and holistic models to meet families' biopsychosocial-spiritual needs following a perinatal loss. There is a tendency for individuals' spiritual sides of self to become heightened at the time of perinatal loss (Public Health Agency of Canada, 2008b). For instances, Fung Lee and Laube's (2008) study illustrated how a Cantonese woman's spiritual and religious beliefs were integral to her ability to find meaning in her loss and her life after experiencing a stillbirth. In order to meet clients' needs holistically, social work needs to consciously and consistently incorporate not only clients' cultural and religious beliefs into bereavement interventions but also their spiritual beliefs and values.

### **Social worker's role in perinatal loss.**

Social worker's understandings of ecological, feminist, crisis intervention, grief, and attachment theories, as well as holistic approaches place them in an ideal position to provide unconditional support to bereaved women and families after a perinatal loss. Social workers are perhaps the most intimately involved in supporting families (Pauw, 1991), and thus play an important role in buffering the negative and long-term effects in the aftermath of these devastating loss events (Cacciatore & Bushfield, 2007). Next, the social worker's role in



providing perinatal loss bereavement support will be discussed with some depth in the following subsections: Active listening, normalizing response, creating memories, family support, group support, and lastly, community referrals.

### *Active listening.*

Steps towards overcoming the silence can first start by providing women with an open and supportive environment to share their stories of loss (Cosgrove, 2004). Actively listening to women's stories is first and foremost in understanding what the loss experience means to them (Cosgrove, 2008; Davidson, 2008; Price, 2008). Language is often a site of oppression. Therefore, it is vital that in discussions with bereaved clients, social workers reflect back their use of terminology (Cosgrove, 2004). In fact, encouraging clients to initiate conversations about their losses using their own terminology, beliefs and values can prove to be an empowering experience for them (Price, 2008). A feminist lens emphasizes the importance of exploring the meaning women attribute to their experience of loss, pregnancy and motherhood. It also aims to understand such meanings and experiences within the context of women's life histories (Cosgrove, 2004). It is imperative that helping professionals be cognizant of, and avoid platitudes such as, "You can always have another child" or "Your child is in a better place now" which are not helpful to the grieving process and even harmful (Cacciatore, 2010). "It's one of the paradoxes of grief that when people try to solve it they cause resentment, whereas if they accept the sadness and aren't afraid to enter into it with the person who is mourning, they lighten the isolation, both the mourner's and their own" (Pector, 2004, p. 721). Misconceptions and oppressive discourses about pregnancy loss and the grieving process must be deconstructed, allowing women to find new understandings, and to construct their own meanings about their losses (Layne, 2003).



### ***Normalizing responses.***

In our dialogue with clients we should discuss normative responses following perinatal loss. In doing so, presumed “pathologies” or “coping difficulties” are re-conceptualized as situational responses to this challenging life event. “Normative” is understood as the most common and typical responses. These grief responses can be viewed as coping and potential challenges rather than judged as inherently problematic or abnormal. Equally important, however, is the fact that normative responses are not universal. Responses to loss vary and are unique to each individual client (Price, 2008). It is important that clients know that grief does not follow a linear process and they are not regressing if they have periods of increased sadness and distress (Cosgrove, 2004). Bereaved parents learn how to move forward with new experiences in life by learning to live with and manage loss while accepting that their loss will remain a part of them forever (Cacciatore et al., 2008). Clients must understand that this loss event is likely to disrupt their life pattern. They should be made aware of what to expect when they return home from the hospital and the potential adverse grief reactions in which case they may require additional support by professionals (Mahan & Calica, 1997; Price, 2008).

### ***Creating memories.***

In addition to having supportive discussions with clients, social workers can encourage bereaved parents’ active participation in the grieving and mourning process (Pauw, 1991). Assisting clients in creating memories is possibly one of the most important interventions to implement as it helps clients actualize their loss and begin to grieve (Rybarik, 2000). Across the literature it is suggested that parents should be encouraged to view, hold, spend time with, photograph, and name their babies. Likewise, assisting clients with collecting mementoes such as photographs, locks of hair, foot prints and other tangible artifacts is an equally invaluable



intervention (Cacciatore, & Bushfield, 2007; Cosgrove, 2004; Davidson, 2008; Malacrida, 1999; Mehan & Calica, 1997; Meredith, 2000). In addition to nursing, social workers are often directly involved in preparing the baby's body for viewing, touching, holding and the taking of remembrance photographs. These bereavement interventions help bereaved parents not only validate their loss but also commemorate their baby's existence, thereby facilitating the grieving and healing process. Also, there have been many reports made by parents of regrets for not being given the opportunity to create memories of their lost child. Thus, these interventions also help to decrease the likelihood of later regrets (Pauw, 1991).

However, in contrast with the above literature, Trulsson and Radestad (2004) mentioned a study that found women who touched their babies were at higher risk of anxiety at follow-up than those who did not. These findings highlighted the importance of timing and preparing women psychologically for what to expect when they view their babies for the first time. A feminist approach validates and respects a range of clients' diverse, personalized and cultural rituals and expressions of grief (Cosgrove, 2004; Davidson, 2008) including instances where women would prefer not to see their baby or collect mementoes (Reagan, 2003). It is also important to be mindful that not all parents desire the same kinds of supports commonly offered (Pector, 2004). Lastly, another element of providing bereavement support includes providing information about, and assisting families with, funeral related arrangements and/or other personalized rituals to memorialize their loss (Pauw, 1991). As this section has illustrated, social workers fulfill various roles when providing bereavement services including that of a supporter, educator, advocate, and facilitator.

### ***Family support.***

The critical importance of social support is a common theme in the literature (Cacciatore



& Bushfield, 2007; Cosgrove, 2004). Thus, social workers utilize ecological-based and family-centered interventions to incorporate women's immediate and extended family and friends into bereavement interventions. By including the entire family, the family's resilience as a whole unit can be emphasized (Cacciatore et al., 2009). Additionally, feminist-minded social workers also recognize gender politics and the importance of gender analysis (Coady & Lehmann, 2008). Fathers' grief responses must not be overlooked. By providing a nonjudgmental, egalitarian milieu, men may be more likely to express their feelings and emotions. Furthermore, discussions with clients about the roots of gender differences in expressions of grief can be used to help couples gain insight into each other's unique grieving styles thereby promoting open communication and understanding between them (Abboud & Liamputtong, 2008; Cacciatore et al., 2008). To further emphasize the importance of ecological-based approaches, a study by Cacciatore et al. (2009b) found that the most important predictor of maternal anxiety and depression after a stillbirth was the level of support from her partner and family. Additionally, the findings indicated that it is most beneficial if bereaved parents have multiple sources of support in place. Similarly, a study by Surkan, Radestad, Cnattingius, Steineck and Dickman (2009) found women who had the opportunity to have open dialogues with their husbands had a 50% decrease in risk of later developing depressive symptoms.

### ***Group support.***

In addition to social support provided by families, group support has been found to buffer the effects of loss (Cacciatore & Bushfield, 2009; Cacciatore et al., 2009a; Pauw, 1991; Price, 2008; Vogel, 1996). Women in Cacciatore and Bushfield's (2007) study reported that the connections they developed with others who had similar experiences as them fostered a sense of belonging and were the most helpful as they mourned the loss of their babies. DiMarco, Menke



and McNamara's (2001) mixed methods, cross-sectional, retrospective, two-group design revealed that while there were no quantitative differences in grief reactions between the participants who attended support groups and the ones that did not, anecdotal data suggested that the groups were helpful. Another mixed methods study showed that women who attended support groups for parental bereavement after a stillbirth had significantly lower rates of post-traumatic stress symptoms than those who did not attend such groups. Furthermore, consciousness-raising was reported as an outcome of the support groups (Cacciatore, 2007), which is consistent with principles of feminist group work (Coady and Lehmann, 2008).

### *Community referrals.*

Lastly, because women are usually discharged within 24 to 72 hours post-pregnancy loss, social workers have only a limited amount of time to implement the most appropriate interventions with this population (Vogel, 1996). Therefore, prioritizing needs and referring clients to on-going community supports is a significant element of providing perinatal bereavement support (Cacciatore & Bushfield, 2007). Further emphasizing the importance of making appropriate community referrals is the fact that few hospitals have formal follow-up services (Cosgrove, 2004). However, there is quite extensive anecdotal evidence that suggests that follow-up services are a beneficial component of perinatal bereavement programs (Black, 1991; Friedrichs et al., 2000; Mahan & Calica, 1999; Vogel, 1996). With this said, hospital follow-up services should be included as a component of hospitals' bereavement protocols, thereby enabling social workers to provide more comprehensive perinatal bereavement support.

### **Implications for Social Work**

Various directions and needs for further research in this field have been identified by researchers. For instance, Cosgrove (2004) identified that within the literature on perinatal loss



the majority of research participants are heterosexual couples. In both research and practice we must also be aware of heterosexual assumptions, recognizing that they further silence the voices of poor, single and lesbian mothers, as well as non-traditional couples who experience perinatal loss. Several scholars (Cacciatore, 2010; Cosgrove, 2004; Price, 2008; Van, 2001) have identified a need for research that explores the strengths and resiliency of women and families after the tragic loss of a baby, which is in line with the emergent literature on post-traumatic growth and trauma. Another deficiency noted within the literature is that the vast majority of empirical studies looked at the psychological impact of loss on bereaved parents (Gerber-Epstein et al., 2009) with a tendency to focus on identifying variables that can predict responses and pathological grief (Cosgrove, 2004; Rich, 2000). Importantly, however, Rybarik (2000) pointed out that by identifying predictors of grief we can be better prepared to implement measures that will promote healthy grieving. Moreover, although there is anecdotal evidence on the efficacy of bereavement interventions, there is very limited empirical research that evaluates specific interventions post-pregnancy loss (Cacciatore & Bushfield, 2007; DiMarco et al., 2001; Gerber-Epstein et al., 2009; Rich, 2000; Stratton & Lloyd, 2008). Equally relevant, there is far more research examining the effectiveness of bereavement services provided by medical professionals (Cacciatore et al., 2009; Davidson, 2008; Stratton & Lloyd, 2007) than there is exploring bereavement services provided by social workers. Although across the perinatal literature there are guidelines for a variety of bereavement interventions that have direct implications for social worker, there is a clear need for more social work related research in this area.

Social workers across all practice settings encounter clients who have experienced perinatal loss and who are grieving in silence, and hurt by the responses or lack thereof made by professionals, family and friends (Cosgrove, 2004). Our encounters with these bereaved families



should convey an openness to listen to their stories of reproductive loss, enabling a full and open dialogue to emerge (Price, 2008). Social workers can play a strong role in facilitating change in societal attitudes, beliefs and values about the perinatal loss experience. Feminist perspectives in social work focus on explaining and responding to the oppressed position of women. Feminist practitioners embrace the re-telling of women's life stories and advocate for their voices to be heard (Payne, 2005). Congruent with social work values of advocacy, self-determination and social change, a feminist perspective and approach can be utilized to deconstruct dominant discourses that oppress and silence women's experiences while at the same time encourage women to construct their own narratives and realities about their losses (Cacciatore, 2009b). As social workers increasingly support women and families in openly speaking about their perinatal losses, it is hoped that society's response to these experiences will eventually evolve in social recognition and understanding.

In summary, there is a need for further research, as well as improved approaches that recognize the significance of a loss as the result of a miscarriage or stillbirth. As has been emphasized thus far, these forms of perinatal loss do not only include the physical loss of a child but also the loss of parents' hopes and dreams—their future is no longer as they had planned. With that being said, the next section of the literature review will discuss another unrecognized loss experience; the loss experienced by parents who involuntarily lose custody of their child.

### **Involuntary Loss of Custody: Another Unrecognized Loss**

A mother who had her child apprehended by the Children's Aid Society stated,

It's a huge loss. It's grief. It's trauma. It's loneliness...It's everything. It affects you in every way imaginable—emotionally, physically, spiritually. It feels like part of you is missing. You can't eat, you can't sleep. It changes your health. It changes everything



about who you are (Novac et al., 2006, p.13).

Most grief experienced by parents who involuntarily lose custody of their child is not socially recognized or supported (Kenny & Druker, 2011; McKegney, 2003; Novac et al., 2006). Consequently, there is limited research examining birthparents' experiences and service needs following involuntary loss of custody of their children (Kenny & Druker, 2011; McKegney, 2003; Novac et al., 2006). McKegney (2003) explains, "Because neglecting parents violate society's Western ideal of what constitutes "good parenting" they are deemed unworthy of expressing their loss" (p. 36). Imbedded in society at large is the perception that these parents placed themselves in a position that put their child at risk; therefore, they are to blame for the loss of custody of their child. "The social response is one of rejection, shunning, and an attitude that they're getting what they deserve" (McKegney, 2003, p. 35). Furthermore, it is usually understood that neglectful parents have dysfunctional attachments or a lack of attachment with their child. Therefore, the parent-child relationship is not viewed as significant and the parent is not viewed as worthy of grieving over the lost relationship (McKegney, 2003). Parents who lose parental rights of their children experience disenfranchised grief because their loss fails to be socially acknowledged, accepted or publically mourned. They are generally isolated and cut off from social supports with little or no opportunity to express and resolve their grief (Kenny & Druker, 2011; McKegney, 2003). As a result of the lack of social recognition for their loss, in addition to, their shame, guilt and fear of disapproval by others, their grief can be intensified and prolonged. These bereaved parents tend to hold onto their grief more intensely and indefinitely than they would if their grief was recognized. The lack of recognition for the grief and the lack of formal rituals surrounding the loss can increase one's risk of continuously re-experiencing the loss as a trauma for years after the loss event. This can lead to depression, anxiety, and



symptoms similar to post-traumatic-stress disorder (Kenny & Druker, 2011). In summary, grief that fails to be recognized cannot be resolved, which in turn can lead to chronic pathological grief (McKegney, 2003). To better understand why this particular loss experience is another unrecognized form of loss, I will now discuss antecedents to infant custody loss.

### **Reasons for Infant Custody Loss**

Some of the most common reasons parents involuntary lose custody of their newborn infants include drug use, poverty, long-term homelessness, serious mental illness, developmental disability, and a history of having other children taken into care. Furthermore, child protection concerns have been found to be associated with lack of prenatal care, low maternal education, single-parent status, unshared responsibility for child care, and poverty (Novac et al., 2006), all of which disproportionately affect the lives of women. Along these same lines, Schen (2005) proposed that "mothers who are separated from their children in traumatic ways are mostly mothers who are cut off from sources of power because of poverty, race, immigrant status, or mental illness" (p. 235). Additionally, the likelihood of an apprehension at birth is also dependent on administrative factors, such as the length of stay in the hospital after the infant's birth and the availability of services including social work. The reality is that sometimes there is not enough time to thoroughly assess child protection concerns or to set up appropriate supports in the brief post-partum hospital stay; therefore, newborns are apprehended as a precaution until a more thorough assessment can be conducted and needed supports can be arranged (Novac et al., 2006).

### **The Loss Experience**

The sparse research that does exist exploring birthparents' experience of having their children involuntarily removed from their custody reveals that these parents rightfully experience



tremendous grief over the loss of their children (McKegney, 2003; Novac et al., 2006).

Regardless of what these parents have done, the majority of them still feel emotional anguish as a result of their loss. The research indicated that birth parents experience disbelief, sadness, emptiness, loneliness, guilt, and anger over the loss of their children (Kenny & Druker, 2011; McKegney, 2003; Novac et al., 2006; Raskin, 1992). At the time of an apprehension, each parent's reaction varies. Some yell, scream, or cry. Some become angry and aggressive. Others appear emotionless (Novac et al., 2006). Parents reported feeling like a failure which is likely amplified by society's disapproval for failing to adequately care and protect their children (McKegney, 2003). Because their loss of custody is a source of shame, their bereavement experience is more often than not hidden from others (Raskin, 1992). It has been said that the process of losing custody of a child, especially if permanent, can be similar to the anticipated death of a child. The experience has been described as a "living death" or a "permanent loss without a real death" (McKegney, 2003, p. 33).

For women whose babies are apprehended at birth there is a profound sense of despair because they are denied their first, and in some instances, their only opportunity to establish an initial bond with their baby. These women also experience an insult to their self-esteem because they are deemed "incapable" or "unfit" mothers (Novac et al., 2006). They lose not only their child physically, but also their ideal or anticipated image of self as a competent mother (Raskin, 1992). In addition to dealing with the physical effects of giving birth and the emotional and spiritual pain inflicted by loss, these women may also experience a variety of somatic symptoms resulting from their loss, including difficulty sleeping, weight changes, and vivid dreams among other effects (Novac et al., 2006). Overall, the traumatic loss experiences are further compounded by a number of factors including the judgment of others, ambiguity and confusion



as to whether the loss is temporary or permanent, the lack of societal acknowledgement and understanding of the loss, and systemic demands placed on them by the child welfare system for reunification with their child (Kenny & Druker, 2010).

### **The Aftermath**

In the aftermath of an apprehension parents are often distraught as well as distrusting of professionals. Not surprisingly, mothers want to leave the hospital immediately after having their child taken from their care, even if leaving is against medical advice. This may place them at risk for postpartum complications, especially if their plan is to return to unsafe living conditions. Furthermore, pregnancy and the birth of a baby place mothers at risk of Postpartum Depression. Therefore, mothers' grief responses following an infant custody loss may be further complicated by Postpartum Depression. Further increasing women's risk of postpartum complications is the fact that service providers who were involved with mothers during the perinatal period, such as public health nurses, are no longer mandated to continue providing services to women whose children are not in their care (Novac et al., 2006).

The social services that are necessary to sustain family life, prevent family breakdown and child placement such as adequate financial security, affordable housing, in-home supports, day care, mental health, addiction counselling and treatment can be lacking in availability and accessibility. These structural problems contribute to this client populations' disenfranchisement (McKegney, 2003). For example, when a child is placed in the care of child protection agencies, parents often lose access to many other social services and resources. Their social assistance payments, housing subsidies or other social benefits associated with having children are usually reduced or even terminated. This threatens parents' ability meet the conditions set out by the child welfare system to have their children returned to their care (Kenny & Druker, 2011). It is



not uncommon for women to terminate relationships with service providers or agencies who they perceive had involvement in having their child apprehended.

Researchers also found that women often resort to, or re-initiate, drug use as a means of coping after having their child removed from their care. Although in some situations custody loss motivates women who abuse drugs to get off drugs and turn their life around, more often it impedes their motivation (Kenny & Druker, 2011; Novac et al., 2006). Another common maladaptive response is rapid subsequent pregnancy (Novac et al., 2006; Raskin, 1992).

An ecological, systems, and feminist theoretical lens allows these parents' custody loss to be understood in light of their past and present life circumstances. Clearly, not only are these parents suffering from a significant loss; they have had to, and continue to, endure numerous challenges along the way (McKegney, 2003). Their lives are complicated by a host of social problems including poverty, substandard housing, physical or mental illness, family violence and abuse, alcohol and drug addiction, among other unfortunate social circumstances. Often these parents were once themselves children who experienced abuse and/or lived in foster care (McKegney, 2003). Most, if not all, women who involuntarily lose custody of their children have extensive histories of trauma (Kenny & Druker, 2011).

### **The Social Worker's Role in Infant Custody Loss**

Social workers are often the most intimately involved in working with, and supporting families who are at risk of having their parental rights terminated. Child welfare practice and policy often serves to exacerbate issues of loss experienced by parents, thereby further isolating and stigmatizing this population (Kenny & Druker, 2011; McKegney, 2003). Every birthmother interviewed in McKegney's (2003) study who had their child removed from their care, spoke of professionals who betrayed their trust, disregarded their feelings, and a system that abused their



authority. This makes it all the more important that social workers advocate for, and demonstrate, a more balanced approach that prioritizes child safety while ensuring consideration for the parents' experience and service needs following such a tremendous loss (McKegney, 2003).

Most importantly, in the event of a loss of custody, social workers need to validate the significance of these parents' losses and empathize with their sorrow. The hospital social worker's role generally entails supporting and advocating on behalf of the family; mediating between the family, the CAS worker and any other professionals involved; and mobilizing social supports including referrals to community resources (Novac et al., 2006; J. Stannard, personal communication, September 20, 2010).

Historically, women with a mental illness and those who conceived out of wedlock were forced into giving their babies up for adoption. In such scenarios, the belief at the time was it was better off if mothers did not develop a bond or attachment to their babies. Thus, it was common practice for these mothers' newborn babies to be whisked away at birth. Many of these birthmothers suffered all their lives with unresolved grief. As opposed to having nothing but vague recollections or fantasies of a lost child, current practice recognizes that supporting birthparents in developing attachments with their child and making memories better enables them to work through their loss and grief (Schen, 2005). Social workers can encourage and foster families in creating memories of their child by supporting them in spending time with and caring for their baby, as well as by helping them gather mementoes such as clothing, foot and hand prints, pictures, and other tangible materials (Novac et al., 2006; J. Stannard, personal communication, September 20, 2010).

The immediate trauma of an apprehension usually makes it difficult for parents to



comprehend and/or retain all of the information they are given (Novac et al., 2006). For this reason among others, it is recommended that the hospital social worker be present to support the family both during and after being informed by child protection authorities of the decision to apprehend their child. This way they can assist families with digesting information regarding the apprehension process and advocate that they be given choices within reason, for example, the opportunity to say goodbye to their baby (J. Stannard, personal communication, September 20, 2010). Additionally, the social worker supports the entire family through this loss process by keeping them informed and providing them with information on how to navigate the hospital system, the child welfare system as well as the social welfare system. Because those involved with the child welfare system are usually from social disadvantaged backgrounds, these parents could benefit from practical assistance in the way of food vouchers, bus tokens and other tangible assistance. Furthermore, as a consequence of their social disadvantage, few are able to represent themselves, make their voices heard, request that their rights be respected and need for services be recognized (McKegney, 2003). Particularly for this reason, social workers should provide information on the legal process and make appropriate legal referrals (Kenny & Druker, 2011; Novac et al., 2006). Overall, an honest, upfront, and hopeful approach that ensures the dignity of the client is not lost in this loss process is most appropriate when working with this client population (Novac et al., 2006; J. Stannard, personal communication, September 20, 2010).

This literature review has illustrated that along with deficiencies in the perinatal loss and custody loss literature there remain tremendous gaps in the delivery of supportive bereavement services to families who have experienced these two loss events. In particular, hospital social workers have the opportunity to actively reach out to women and their families to help them



express their voices after the loss of a baby. Guided by a feminist perspective, the aim of this literature review was to bring awareness to the experience and service needs of women and their families who have suffered these unfortunate loss events. Through developing my own knowledge in this area, I hope to be better able to provide feminist-informed social work interventions whereby families can openly express their experiences of perinatal loss and custody loss and have their service needs met in a holistic manner. In the next chapter, I will discuss the process of the practicum, which will address pertinent questions pertaining to my practicum including where I did it, what I did, how I did it, who helped me, and why I did what I did.



### **Chapter 3 – The Process of the Practicum**

To fulfill part of the requirements for the Laurentian University M.S.W. program, I engaged in an Advanced Practicum (SWRK 6024R) from September 13, 2010 to November 30, 2010. The practicum setting was the Paediatric and Obstetric departments, as well as the NICU of Orillia Soldiers' Memorial Hospital. In this Chapter I will begin by describing the advanced practicum environment and the agreements made with the organization in order for the practicum to take place. Next, I will provide details pertaining to the supervision I received during my practicum and outline the training plan I followed. Finally, I will discuss the theoretical lens that guided my practicum, and lastly, consider both researcher reflexivity and reflective practice.

#### **Description of the Advanced Practicum Environment**

Orillia Soldiers' Memorial Hospital is 230-bed facility which provides regional level programs and medical and surgical services to residents of North Simcoe County and Muskoka. The Maternal, Child & Youth social worker covers the Paediatric and Obstetric department, as well as the NICU. The program provides Level 2 (intermediate) paediatric and obstetric care to support infants, children and youth from 0 to 18 years of age and their families, as well as offers a variety of comprehensive outpatient services to families. Many community hospitals across North Simcoe Muskoka and beyond refer families to OSMH because the program is well equipped to support pregnancy related complications whereby specialized perinatal services and a Level 2 NICU are required. Over 900 babies are born each year at OSMH. The Maternal, Child & Youth program utilizes a multi-disciplinary team approach and values family-centred care where personal, cultural and religious choices are considered and respected (OSMH, 2008).

As already mentioned, the majority of my advanced practicum experience took place on the obstetric department and the NICU where I worked with families experiencing a variety of



pregnancy and birth related complications and issues, including but not limited to, prematurity, infants born with anomalies (i.e., down syndrome), perinatal loss, adoption, teenage pregnancy, addiction issues, postpartum depression among other mental health concerns, single parenthood, domestic violence, and child protection issues. I also spent some time providing social work services within the paediatric department to children, youth and their accompanying families for a variety of biopsychosocial issues, such as child related illnesses and conditions, physical and intellectual disabilities, mental illness, behavior issues and child protection concerns (i.e., child abuse and neglect, poverty). Prior to starting my advanced practicum I had no previous social work experience working in this advanced practicum environment.

### **Agreements with the Organization**

Prior to starting my advanced practicum, Suzanne Lacelle (placement coordinator at the School of Social Work) confirmed with Amy Hope, the Human Resources Associate at OSMH, that a placement contract was in place between Laurentian University and OSMH. I accepted OSMH's offer of placement and completed the necessary workplace agreement forms. As a Master of Social Work student, my mandate was to provide family-centred support to clients accessing services through the Maternal, Child & Youth program. Entrusted responsibilities included maintaining client confidentiality. In addition, I effectively worked within a multi-disciplinary team and collaborated with many other OSMH services and community partners to ensure seamless access to quality care from pre-conception, to prenatal, postnatal and paediatric care. The program's family-centered maternity care approach required that I consider clients in relation to their family units and respect their personal, cultural and religious choices (OSMH, 2008). Resources at my disposal included clients, client files, hospital staff, the program manager and director, my supervisors, community agencies and their staff, reading material on the unit,



the hospital library, and research literature.

### **Supervision**

Anne MacDiarmid was my agency supervisor. She has over 22 years of social work experience working with children, youth and families. She graduated from McGill University with a Bachelor of Social Work in 1988. After graduating, she worked with children with disabilities and troubled adolescents for four years. Anne graduated with her Master of Social Work from the University of Toronto in 1992. She then worked at Bloorview Children's Hospital from 1992 to 2004 where her focus was on children with disabilities, chronic illnesses and their families. In 2004, she went to OSMH where she worked in dialysis for two years, then adult mental health for three years. She then moved on to her current position in obstetrics and paediatrics where she has been for two years (A. MacDiarmid, personal communication, March 19, 2010).

For the first few weeks of my practicum, I was closely supervised by Anne. I more or less shadowed her thereby having an opportunity to become familiar with the practice environment, as well as with the social work role specific to this practice setting. Thereafter, I worked independently with clients while having Anne easily accessible for regular face-to-face consultation and supervision when required. Anne shared an office which had two work stations with another social worker. However, the other social worker was rarely in the office; therefore, I had my own work station for most of my practicum. On occasions when the other social worker was occupying the second work station, Anne and I shared hers. In addition to having on-going discussions about client situations throughout the week as time permitted, Anne and I made time to meet formally once a week for an hour to debrief, discuss client issues, and my clinical progress. We made use of various resources to facilitate reflection on practice, including my



weekly reflective journal, attending weekly medical rounds on the unit whereby case studies would be discussed, attending monthly care team meetings, and attending “lunch and learns”. However, the reality of practice was that despite being a student who had access to direct supervision, there were times when due to the work load and time constraints debriefing would have to be postponed until a later date. In such instances, it was especially important that I set aside time for myself to make reflective notes because otherwise I would have forgotten the details of important practice issues that I wanted and needed to discuss.

### **Training Plan**

My overall objective for completing an advanced practicum was to develop advanced clinical skills in social work intervention with individuals and families within a medical setting. More specifically, my training goal was to advance my knowledge and clinical skill in dealing with loss and bereavement with a focus on loss and bereavement related to the perinatal period.

As a result of the fast paced and highly demanding nature of the obstetric, special care nursery, and paediatric departments, I developed advanced clinical skill in implementing crisis intervention, problem-solving, and solution-focused approaches. In order to effectively provide social work services within this setting I also had to become familiar with the operation of the hospital's organizational structure, and the policies and procedures most relevant to social work interventions. Additionally, my increased familiarity with the community resources available in Orillia and surrounding areas has enhanced my ability to effectively collaborate with community partners. In addition to gaining advanced knowledge and skill in loss, grief and bereavement interventions, I became familiar with common obstetrical and paediatric related issues, the Child Protection Act, Mental Health Act, and consent and capacity issues.

Importantly, my practice decisions integrated theoretical knowledge, evidence-based



research, and practice wisdom. A wide range of sources of knowledge assisted me in meeting my training objectives. These sources of knowledge included past experiences, theory, research, clients' perspectives, the organization, its dynamics and politics, supervisors' and co-workers' perspectives, as well as social work ethics and values. I also took advantage of opportunities to foster my on-going professional development by networking with community agencies and other professionals, attending in-hospital presentations and professional rounds, as well as by attending a conference on trauma and another that spoke to bereavement issues in the perinatal period. A sense of curiosity, an openness to change, and a willingness to seek out new learning opportunities was key to advancing my clinical knowledge and skill.

### **Theoretical Lens**

Feminist social work theory is a core theoretical paradigm that guides my social work practice. A diverse body of feminist theory informs social work knowledge, practice and research (Payne, 2005). Feminist principles are closely aligned with many social work values and ethics (Lazzari, Colarossi & Collins, 2009; Turner, 1996). Some even argued that social work is inherently feminist (Lazzari et al., 2009), and I would agree with this viewpoint. Feminist perspectives in social work focus on explaining and responding to oppression generally and the oppression of women in particular. Broadly speaking, feminist social workers are concerned with the political, social and cultural, as well as other forms of domination of women by patriarchy which disfranchises, disempowers and devalues women's experiences (Payne, 2005).

As a social worker working from a feminist framework, I value the principles of empowerment, the process, the personal is political, diversity and consciousness-raising (Turner, 1996). I embrace the re-telling of women's life stories and advocate for their voices to be heard.



In addition to drawing on feminist values and goals, my generalist eclectic practice approach incorporates a variety of different social work theories and approaches, including but not limited to holistic, strength-based, ecological, and systems approaches. Additionally, a biopsychosocial-cultural-spiritual model enables me to think holistically and appreciate that individuals' biological makeup, body, cognitions and emotions, social environments, and cultural and spiritual identities are interconnected and equally important. Furthermore, as a feminist-minded social worker it is vital to view individuals' health and well-being in relation to larger systems, including their past and present environments, social supports and community resources and wider societal structures. Thus, as I discussed throughout the Literature Review, The Process of the Practicum, Reflection on and Critical Analysis of the Practicum Experience, and the Conclusion, this paper illustrated how feminist values, processes, and analyses guided and informed my advanced practicum research and practice.

### **Researcher Reflexivity**

Relevant to my focus on loss and bereavement, over the years, women in both my personal and professional life have self-disclosed to me their experiences of perinatal loss. What stood out most in their stories were the long-lasting effects these devastating experiences had on their lives. In each of the disclosed stories, the women shared feelings of being judged by others and feeling alone in their grief. The psychosocial issues that lingered and influenced their everyday life made it evident to me that they did not receive the social support that they could have greatly benefited from. In my encounters with helping and health professionals, as well as with non-professionals it is apparent that there a lack of understanding about the experience of perinatal loss and even less awareness about the practices that facilitate the grieving and healing process for those affected by these loss events. This realization was the impetus of narrowing



my research and practicum focus to perinatal loss. I have not experienced perinatal loss myself and I have yet to become a mother. I am, nonetheless, a woman and one who has been touched by the stories of women who have experienced a variety of perinatal losses. Furthermore, I am a social worker guided by feminist principles who is committed to helping break the silence that leaves individual and families alone in their grief.

In preparation for my advanced practicum, I looked at the perinatal loss literature and came to understand perinatal loss as any loss experience surrounding pregnancy, including abortion, miscarriage, stillbirth, neonatal death, the birth of a baby with medical or special needs, infertility and adoption situations. Although I anticipated working with clients experiencing a variety of these perinatal issues, my primary focus was on developing advanced knowledge and skill in working with clients experiencing miscarriages and stillbirths. Hence, I started out my practicum well prepared to work with clients experiencing perinatal loss in the form of miscarriage and stillbirths.

Unexpectedly, however, within the first few weeks of my practicum I worked with a larger than normal number of parents facing the potential involuntary loss of custody of their newborn babies. After working directly with a few families who had their newborn baby's apprehended by the Children's Aid Society (CAS) within the first few weeks of my practicum, it became apparent to me that these parents' and families' loss experiences were undervalued and their service needs were not adequately being met. Additionally, there was no hospital policy or procedure on how to best support these families during this specific loss event. Although not recognized as such in the literature, I also came to view the apprehension of a newborn and the associated loss and grief the parents experienced as a form of perinatal loss. Child welfare policies and practices have been criticized for exacerbating issues of loss, ultimately



disenfranchising this already isolated and stigmatized population of bereaved families (McKegney, 2003), and I argue that hospital policies and practices sometimes do the very same. In my practicum, my first few experiences of apprehensions almost exclusively focused on ensuring the safety of the child and the environment. As a result, the parents of the children who were apprehended received very little attention and support from the professionals involved including from hospital social workers. In coming to this realization, I saw the need to expand my focus on perinatal loss and bereavement to include loss and bereavement following the involuntary loss of custody.

To put my experience into perspective, within the last two years my supervisor reported working with three families who had their children apprehended while in the hospital. During the three months of my practicum, I worked directly with approximately 15 families who were at risk of losing custody of their children; six involuntary lost custody of their children during their hospital stay, and four of these six were apprehensions of newborn infants. Additionally, during the course of my practicum, I provided direct practice to five families who experienced either a late miscarriage or stillbirth.

### **Reflective Practice**

Importantly, during my practicum I engaged in critical reflective practice. A daily reflective journal was an integral aspect of my advanced practicum. In my reflective practice journal I recorded integration of practice and theory, clinical progress and questions that arose. I used it to record any significant and/or difficult practice situations and my thoughts and feelings as they related to these specific practice issues. Looking back at the facts of a case, seeing what I did, and how I might improve future practice was an invaluable tool to learning and developing my clinical practice. To be effective practitioners, however, we need to move beyond the "what



and how” and ask ourselves “why” we do what we do (Knott & Scragg, 2007). By subjecting my practice to the question “why” and sharing these reflections with my supervisor, I was able to make explicit the assumptions, beliefs and values behind my actions. Thus, I became cognizant and critical of how unchallenged emotions, assumptions and personal beliefs can impede my own and others’ professional decision making. Feminist social workers value reflectivity. They recognize that counter-transference is inevitable within the therapeutic relationship and that it can be a valuable source of information about the social worker, the client, and the therapeutic relationship itself (Cosgrove, 2004).

In addition to enabling me to conduct a critical analysis of my own practice, my reflective practice journal acted as a record of my practice interventions with clients who experienced perinatal loss and infant custody loss. Thus, my reflective journal was fundamental to the development of the next section of this report that discusses my reflections and critical analysis of the practicum experience. This discussion illustrates how my clinical knowledge and skills in dealing with loss and bereavement progressed and improved over the course of the practicum experience.



## **Chapter 4 – Reflections on and Critical Analysis of the Practicum Experience**

In this Chapter, I will discuss my reflections and critical analysis of the practicum experience. With the help of my reflective practice journal, I was able to develop the discussion herein that reflects the themes that emerged from my advanced practicum experience, as well as demonstrates the advancement of my knowledge and skill in working with loss and bereavement specific to the perinatal period. The themes that will be the topics of discussion are as follows: the loss experience and grief response; my social work interventions responding to loss and grief; the issues of choice and control; the need for improved services; and lastly, practice challenges.

### **The Loss Experience and Grief Response**

After having some experience working with parents who experienced either a perinatal loss or custody loss, I began identifying similar features in their loss experience and grief responses. The most consistent similarity between these two forms of loss is that these parents share the loss of a child which is believed to be the most profound loss a person can experience (Zeman, 2005). These parents' attachments to their babies and expectations of parenthood generally developed along with their babies during pregnancy, yet despite developing such attachments, they all walked out of the hospital as bereaved parents with empty arms. To me this unfortunate similarity conveys the significance, as well as the tragedy of these losses. Families who experience a loss of a child are in crisis and initially experience a state of shock. Although each bereaved parent had a unique response to their loss, some responses more overt than others, both groups of parents experienced the typical grief process. Clients typically displayed expressions of denial, shock, disbelief, sadness, searching and yearning, anger, bargaining, and depression.

One key difference in the grief process for parents who experienced perinatal loss verses



custody loss is the nature of guilt, self-blame, and shame (Raskin 1992; Zeman, 2005). Guilt, anger, and even self-blame are almost always seen in maternal bereavement. However, there is typically more shame associated with custody loss (McKegney, 2003). Feelings of shame reported by parents following a perinatal loss where all routine prenatal precautions were taken may indicate a problematic grief response. On the other hand, in a situation of custody loss, the absence of guilt, self-blame or shame felt by parents may signify denial of the loss and/or circumstances leading to the loss (Raskin, 1992). At the same time, however, it is not uncommon for these parents to blame others for their loss; especially the individuals who they perceive contributed to involving the child welfare system in their lives. Additionally, parents who lose custody of their children are far more likely to be shamed by others than those who have a perinatal loss (Kenny & Druker, 2011).

It is important to note that unlike in many custody loss events, parents who suffer a perinatal loss will never have the opportunity to physically have their child be a part of their lives. This being said, there are also instances where parents lose custody of their children at birth and for whatever reason never regain custody or have their children physically a part of their lives either. In comparing the similarities and differences of these two loss experiences, my intent is not to diminish one or the other or imply that they are the same. Rather, based on my advanced practicum research and experience, my intent is to present an accurate account of the experience and service needs of families whose lives are affected by these too under-acknowledged and inadequately supported loss events. We too often place losses on a scale ranking their severity and/or significance and provide bereavement support accordingly. Instead, we should be focusing on each client's unique perceived experience of their loss and their equally unique service needs. Importantly, although a comparison of these two loss events can



inform practice, I would never minimize an individual's loss experience by suggesting to them that their loss is similar to another person's or another form of loss.

### **My Social Work Interventions: Responding to Loss & Grief**

In my initial meetings with families one of the first things I did in an attempt to establish rapport was introduced myself and provided a clear explanation of what it was that a hospital social worker does. This was very important because unlike doctors or nurses, social workers' roles are not as well understood by the general public. Likewise, often clients who were anticipating CAS involvement and/or had negative past experiences with social workers would automatically perceive me as a threat the minute I indicated that I was a social worker. In an attempt to gain clients' trust it was essential that I cleared up any misconceptions about what my role was as the perinatal social worker from the onset.

Additionally, avoiding insensitive clichés was just as important when working with parents who lost custody of their child as it is with families who had a perinatal loss. Professionals have been heard saying inappropriate and hurtful comments to parents following perinatal and custody loss events, such as, "I understand your loss" or "This is difficult on us (the professionals) too" (J. Stannard, personal communication, September 20, 2010). I found expressing my condolences and saying something along the lines of "I cannot imagine what you must be going through right now," validated the difficulty of these clients' loss situations and helped in establishing rapport.

Assessment of clients' loss and grief responses required attentively listening to their stories of loss and the meaning they attributed to their loss. This meant exploring separately what the loss meant to the woman, to her partner, to the parents as a couple, and to family members. Determining if the parents' and families' understanding of the loss was congruent with the



present reality of the situation, and assessing where they were at in the grief process was essential to providing appropriate and sensitive bereavement interventions. There were instances where I realized through my discussions with clients that they were still in denial about their loss and had I not recognized this and adjusted my interventions accordingly, I likely would have compromised the therapeutic relationship.

Parents who faced the loss of a child experienced a sequence of emotional phases. I utilized my knowledge of grief theories to help normalize clients' feelings following loss. Normalizing families' responses to trauma and loss involved discussing the stages of grief in terms of a process and acknowledging that although their situations were unique, their responses were not unusual. Additionally, during this time when clients were experiencing strong emotions of hopelessness, it was important to emphasize their strengths, such as the presence of a caring support system, or their ability to overcome past adversities. Equally important as recognizing the psychological effects of perinatal or custody loss in my practicum, was acknowledging the physiological effects pregnancy, birth and the loss process had on women. It was vital that as a team we prepared these parents for what to expect emotionally, as well as physiologically (i.e., breast engorgement, sleep disturbances, mood fluctuations). I also often provided education and reading material on the signs and symptoms of Post-Partum Mood Disorder.

An ecological, systems, and feminist approach was critically important to my direct practice because the emotional impact of perinatal loss and loss of custody was felt not only by parents but also by the entire family and close family friends. Therefore, with clients' consent, to the greatest extent possible, I would try to involve the whole family and close friends in my interventions. This consisted of having discussions with families about the impact of loss on particular family members (i.e., siblings and grandparents), and providing appropriate



bereavement reading material.

Unfortunately, as evidenced in the literature (Abboud & Liamputtong, 2008; Cacciatore et al., 2008, Kohn et al., 2000; Novac et al., 2006) and in my practice experience, professionals (including myself) can continue to overlook the emotional impact of the loss of a child on fathers. Further contributing to the tendency to overlook fathers' responses to loss, the fathers tended to hold back their emotions and presented as having little or no difficulty coping. Thus, the importance of a gender analysis that acknowledges the impact of loss, specifically on fathers, and the differences in men's and women's grieving styles, became even more apparent as I gained more experience. Moreover, fathers may be better supported by perinatal social workers if given an opportunity to speak separately from their partners.

Additionally, there were other times when it was necessary to assess and provide interventions to parents separately. There were a few custody loss scenarios whereby one partner posed a security risk (i.e., history of violence) while the other did not. In my opinion, as a result of the security concern posed in these cases by fathers, mother's loss experiences and service needs were inadequately addressed. These particular situations heightened my awareness of the need to conduct assessments and interventions in a way that does not allow one parent's security risk to undermine the quality of bereavement service provided to the parent who does not pose a safety concern. Likewise, ensuring partners were assessed individually and had an opportunity to speak with me privately was absolutely critical in situations where domestic violence was suspected.

Also in harmony with an ecological, systems, and feminist approach, I was cognizant of how practitioners (including myself) were emotionally affected by the clients' difficult circumstances and loss experiences. As the social worker, I worked intimately with these clients



and vicariously experienced their loss. I also had an emotional investment in their outcomes. A team approach was crucial to preventing me from becoming overwhelmed when working with these particularly difficult issues. I was affected by families', other professionals', and my own sadness when parents lost their children. Although I do not have children of my own, I could not bear to think of losing a child. I also felt frustrated by the lack of understanding and sensitivity for these parents' losses and the limited resources readily available to them. Given the emotional nature of this work, it was imperative that I scheduled time to regularly consult with my supervisor and debrief after particularly difficult client situations. I also attended to my self-care needs by getting adequate sleep and exercise, and making time to do activities I enjoyed. As Ilse's (1996) emphasized, "If you are to give from your well, it must have water" (p. 2).

My ability to respond to clients' loss and grief was also dependent on developing effective working relationships with other professionals within the hospital, as well as with local social service providers. Networking acted as a source of professional support and development, which better enabled me to holistically and culturally support and meet the services needs of bereaved parents. Taking advantage of opportunities to speak with the hospital's chaplain and Aboriginal liaison on a regular basis provided me with some great insight into working with individuals affected by loss. For example, the Aboriginal liaison made me aware of the positive impact organizations and professionals can have on clients' experiences when they make a conscious effort to acknowledge the cultures of the clients they serve. Additionally, the hospital's chaplain stressed the importance of self-care in working with loss. He emphasized the benefit of having a balance between the energy we put into our professional lives and the time we put into our personal lives.

In my discussions with clients I would inquire about any cultural, religious, or spiritual



beliefs or practices they had. I would inform clients of the hospital's pastoral and Aboriginal liaison services. I would also welcome them to use the hospital's worship centre, ensuring they understood that the pastoral services and worship centre were open to all individuals regardless of religious or spiritual affiliation. Frequently, this would open up the forum for discussions about culture, religion, and spirituality. Some clients shared their past and current beliefs in relation to life, death, religion, and spirituality. Usually, however, the depth of these discussions took place before the delivery of an expected perinatal loss because after delivering, understandably, most parents wanted to leave the hospital as soon as possible.

Similarly, immediately after an apprehension, mothers would again understandably want nothing more than to leave the hospital as quickly as possible. At their request, they would be discharged from the hospital shortly after the apprehension took place. As a client advocate, I often facilitated a speedy discharge process by mediating between the client, the medical staff, and the CAS workers. In the midst of these crises, clients' immediate wants and needs often took precedence over taking time to explore what their loss meant to them. The focus remained very much on the "here and now", and often times on meeting their basic needs. However, whether before an actual apprehension takes place or by means of follow-up services, these clients also needed to be given the opportunity to more thoroughly explore what their loss meant to them with a supportive professional. Additionally, it also needed to be routine practice to inform these families about the hospital's pastoral and Aboriginal liaison services. Overall, following either of these loss events, all clients should be provided with supportive bereavement services that give consideration to their unique cultural, religious, and spiritual needs.

### **Disenfranchised grief.**

As was discussed in the Literature Review, disenfranchised grief is experienced by those



whose significant losses are deemed illegitimate by society (McKegney, 2004). These two very different yet similar loss events share a history of being under-acknowledged and devalued experiences. Therefore, among the similarities between loss from a miscarriage and stillbirth and the loss following an apprehension is the disenfranchised grief associated with these loss experiences (Cacciatore, 2009; Cacciatore et al., 2008; Cosgrove, 2004; Kenny & Druker, 2011; McKegney, 2003; Novac et al., 2006; Price, 2008). Due to the stigma and shame associated with custody loss, these parents are more often blamed for their loss and face even greater barriers to accessing social supports. Thus, they are often even more isolated than parents following a perinatal loss. These significant loss experiences continue to be undervalued by professionals and the accompanying grief receives little acknowledgment by society at large. I think partially due to professionals' and society's lack of understanding for, and comfort with, the reality of both the loss of a pregnancy or the loss of custody, parents' difficult feelings and service needs are too often avoided, misunderstood, or just outright ignored. This lack of acknowledgement leads to isolation, thereby increasing both of these groups of bereaved parents' risk for complicated grief.

In traditional grief counselling, clients are given "permission" to ventilate strong emotions associated with their loss. When a family experienced a perinatal loss it was my experience that they were better supported in expressing their emotions than families who had their children apprehended. With child apprehensions, it was not uncommon for parents to become defensive, angry, and even hysterical. As the mediator between the client and the CAS, I validated the clients' intense emotional reactions, yet encouraged them to maintain a sense of self-control, cooperate with CAS, and refrain from expressing anger, especially towards the CAS worker. I would try to shift the focus of their anger away from the CAS worker and more toward



systemic problems and/or point out exceptions when the child welfare system was effective. Additionally, I would remind these clients that hearsay and displays of anger or aggression could be damaging to their case in court. While it was important to ensure that these parents were aware of the potential consequences of their actions, it was equally important that with my support and in a safe and private area of the hospital, they be given an opportunity to express their intense emotions including anger and frustration regarding their loss situations.

Emphasizing my role as a supporter and validating their losses as significant, as well as empathetically and in a non-judgmental way listening to their stories, were some of the most important interventions I provided to alleviate clients' feelings of disenfranchisement following a perinatal or custody loss. I also encouraged parents to share their emotions with other professionals and supportive people they trusted in their lives. I initiated conversations about past patterns of coping and provided support around healthy coping. In addition to confronting clients' urges to use maladaptive coping behaviours, such as ignoring and/or numbing feelings by turning to substance use, I encouraged harm reduction behaviours. Furthermore, the literature reveals that in hopes to fill the emptiness after a perinatal or custody loss women report an urgency to become pregnant again soon after their loss. Although I did not have such conversations with clients, empathetically acknowledging temptations for rapid pregnancy, while explaining how it would be detrimental to their ability to grieve and heal may have been useful with some of the clients with whom I worked.

### **Anticipatory grief.**

Anticipatory grief which describes when an individual anticipates a loss and begins to grieve and mourn before the actual loss occurs (Kohn et al., 2000) was another reoccurring theme that emerged from my practicum experience. Parents who had a previous perinatal or



custody loss, who knew before delivering that they were going to have a miscarriage or stillbirth, and those who knew custody loss was probable but had yet to have their baby officially apprehended struggled with anticipatory grief. Furthermore, those who had experienced a previous loss had a tendency to anticipate a subsequent loss; therefore, they avoided becoming overly attached to their babies. For some, in addition to continuing to struggle years later with accepting their previous loss, their present circumstances of loss were triggering, even amplifying their past losses. I learned from my experiences, that it is better to address and normalize anticipatory grief as soon as possible; otherwise clients become too overwhelmed by the anticipation of their loss. In such cases, in addition to providing support surrounding the intensity of their loss responses and/or the impact of numerous losses, I would involve a crisis worker for added family support, make a referral to a community mental health agency and/or before the client was discharged, ask for a psychiatric consult within the hospital.

### **Ambiguous loss.**

Relevant to both perinatal loss and custody loss is Pauline Boss's concept of "ambiguous loss". Pauline Boss (as cited in Kenny & Druker, 2011; Zeman, 2005) describes ambiguous loss in terms of when a person is physically absent but psychologically present or when the reverse exists. While the children are not physically present following a perinatal or custody loss, they are still very much a part of the family psychologically (in the family members' thoughts). Therefore, from family members' perspectives these two forms of loss have a tendency to lack clarity and closure in turn contributing to their disenfranchisement (Kenny & Druker, 2011; Zeman, 2005). When a child is lost either as a result of perinatal loss or the loss of custody, the loss is difficult to resolve because often the parents become preoccupied with thoughts about the lost child. Unlike when an elderly family member dies whereby the loss is a recognized and



acknowledged form of loss with prescribed rituals, in instances of miscarriages, stillbirths and the loss of parental rights, the loss experiences are surrounded by uncertainty and confusion. For example, many of these parents are uncertain about how to answer the question "How many children do you have?" (Betz & Thorngren, 2006).

These parents may no longer know what their roles as parents entail. Not only have they physically lost a loved one physically, but they also perceive that they lost their dreams and future as a mother to these specific children (Kenny & Druker, 2011). Despite their loss, they need to be acknowledged as parents for life. In the case of loss of custody, the loss may be perceived as reversible adding to the ambiguity (Kenny & Druker, 2011; Zeman, 2005). The lack of formal rituals and recognition of grief can increase one's risk of continuously re-experiencing the loss of trauma for years after the event (Kenny & Druker, 2011). Ambiguous losses are said to be the most difficult to recover from due to the lack of clarity that occurs when people are waiting for an end to the loss response or a return of the lost loved one (as in temporary custody loss) (Zeman, 2005). Understanding this concept in relation to these loss events gave me insight that enabled me to speak to clients about the difficulty, yet sometimes the necessity of having to accept the "unknown", for example, not knowing the cause of a pregnancy loss, who made a report to CAS, or future childbearing or childrearing abilities. As difficult as it for clients to accept, I would remind them of the reality that there are some things in life that are beyond our control. At the same time, it was important to counterbalance uncertainty by drawing on clients' strengths and finding sources of hopefulness for the future.

### **Choice and Control**

The need for a sense of choice and control is a central theme that is reflected in the literature (Cacciatore, 2009b, 2010; Cacciatore & Bushfield, 2007; Cosgrove, 2004; Gerber-



Epstein et al., 2009; Kenny & Druker, 2011; Kohn et al, 2000; Layne, 2003, 2006; Novac et al., 2006; Price, 2008) and became ever present in my practice experience. In both of these loss events, the parents and families are often left feeling powerless over the current events in their lives. In recognizing this, I advocated that bereaved parents be given choices and as much control over their loss experience as possible. In an effort to promote client self-determination, it was critical that parents be fully and accurately informed early on about policies and practices related to their loss events. Unless contraindicated, this also involved being forthcoming with information about what to expect specific to their loss and providing families with relevant written bereavement material. The more informed clients were, the more say, and hence, control they had over their loss situation.

In both loss scenarios, I acknowledged and supported bereaved parents in their roles as parents. In perinatal loss situations, I provided parents with choices regarding seeing, holding and caring for their baby. I also reviewed with them their options in terms of commemorating their baby, funeral and other related services, and having an autopsy. With parents who lost custody of their children, I also advocated on their behalf for time with their baby before being taken by CAS from the hospital. By being present while CAS informed the family of their intent to apprehend, I could ask the CAS worker to clarify information and address any misunderstandings and hopefully alleviate some of the parents' feelings of powerlessness.

Another means to provide parents with choice was by helping them create remembrances and mementos. I assisted bereaved parents with the collection of mementos of their babies, such as photographs, clothing, blankets, identification cards, among other tangible materials. All of the families I worked with who experienced a perinatal loss during my practicum delivered after-hours or on the weekend. Therefore, I was not present during the actual taking of the



remembrance photographs and hand/foot prints. I did, however, print and prepare for pick-up all of the remembrance photographs parents choose to have taken of their babies. In my conversations with mothers who had a perinatal loss, it was apparent that those who had the opportunity to have remembrance photographs taken of their babies derived great meaning and comfort from them.

Similar to the interventions provided to parents who experienced a perinatal loss, in child apprehension situations, I encouraged and assisted families with collecting mementos. On a few occasions, resources allowed for parents to be provided with a small gift to give to their baby. Additionally, in a few custody loss situations, parents were supported in taking photographs of their baby. Although in many instances birthparents regain custody of their children, as professionals working with these parents we must ensure that such assumptions do not prevent us from providing invaluable bereavement interventions. As the perinatal social worker, there was no way of knowing for sure if these parents would or would not be reunited with their children. Furthermore, in the child custody loss literature (Kenny & Druker, 2011; McKegney, 2003) parents often speak of promised pictures of their children that they never received from CAS. Additionally, with each pregnancy the post-partum experience is time-limited and no aspect of its importance or the opportunity for parent-child bonding should be taken for granted. Thus, taking the time to support these families in obtaining photographs of their babies before being apprehended was a very beneficial intervention.

Also relevant to creating lasting memories of lost children in my practicum, bereaved parents who had late miscarriages or stillbirths would be given a "memory book" where pictures of, and text about, their babies could be stored for safekeeping. Likewise, "life-books" that documented details about the child's history are often provided to foster parents when a child



entered a foster home. McKegney (2003) suggested that birthparents who have their children removed from their care be helped in creating a booklet that entails pictures, mementos, and text reminding them of their children. I propose that with the help of the perinatal social worker such booklets could be started in the hospital in a situation where a child apprehension is likely.

Lastly, the importance of rituals is another dominant theme that emerged in the literature and from my practicum experience. The lack of rituals to honour both of these loss experiences makes it that much more important for social workers to encourage and support bereaved families in creating personalized rituals that will enable them to honour their loss and find some sense of peace that will allow them to move forward. Rituals are also a form of creative self expression which helps people make sense of their place in the world, find purpose, heal, and grow. Ultimately, rituals can be an outlet for grief (Seftel, 2006). They are also often linked to individuals' religious and spiritual beliefs, values, and practices. In discussions about rituals often clients revealed what gave meaning to their life. Some of the rituals clients I worked with utilized included painting, knitting, writing, planting a tree or flower to signify their loss, lighting a candle, wearing a piece of jewelry to symbolize their lost loved one, and even creating a foundation in honour of their loss. Additionally, in a pending custody loss situation, the client and all the professionals involved took part in a smudge ceremony, thus promoting holistic and culturally sensitive bereavement support.

### **The Need for Improved Bereavement Services**

I was pleased that my experience revealed professionals are doing a better job at supporting bereaved families after a perinatal loss than was indicated in the literature (Cacciatore, 2009b, 2010; Cacciatore & Bushfield, 2007; Cosgrove, 2004; Gold, 2007; Kohn et al., 2000; Layne, 2006; Malacrida, 1999; Pector, 2004; Price, 2008; Stratton & Lloyd, 2008). The



Orillia Soldiers' Memorial Hospital policy for perinatal loss, as well as a Perinatal Bereavement Checklist (see Appendix A) not only reflects the importance of medical care but also emotional support. In addition, following a perinatal loss each family is provided with a well developed Perinatal Bereavement Package among other bereavement reading material. In reality, however, the quality of bereavement services provided also depended on a number of other factors, including funding, resources, and the availability of social work and other bereavement related services. Unfortunately, despite having a perinatal loss policy in place, there were funding, resource, and time constraints thereby making it difficult and impossible at times to provide clients with the ideal bereavement support as outlined in the policy. For example, some of the bereavement supplies needed to be updated and expanded; however, there was no funding available to do so. Additionally, mainly due to time constraints, follow-up services were not delivered as per the policy. Fortunately, I found the time to provide follow-up in the way of telephone calls and sending personalized bereavement cards to most of the families I worked with.

As I have already mentioned, my initial practice experience made it apparent that parents' support needs were inadequately being met in the event of a child apprehension. In contrast to the perinatal loss policy, the policy and procedure for the apprehension of an infant/child failed to mention anything about providing support to the families. In addition, it lacked clarity and detail regarding what the professionals' roles and responsibilities were in the event of an apprehension (see Appendix B). Furthermore, there was no established bereavement related material to provide to families in the event of a child apprehension. After reviewing the child custody loss literature, talking to professionals both within and outside of the hospital, and drawing on my practicum experience, my supervisor and I collaboratively developed an



Apprehension Consideration Checklist (see Appendix C). This checklist promotes a team approach to ensuring the safety of children, while also providing support to families in an event of an apprehension. Once final approval is made by the appropriate review committees, this document will be added as an attachment to the original Infant/Child Apprehension Policy.

Additionally, I identified a need for more resources that provide bereavement support specific to parents who have suffered a loss from these two very specific loss events both within Orillia Soldiers' Memorial Hospital and in the surrounding communities. It was made clear that within the Maternal, Child, & Youth program there was no funding available for the development of loss and bereavement groups. Unfortunately, funding constraints in smaller cities and hospitals limit the services available when compared to larger cities such as Toronto. Despite the limited resources available, I thought it would be helpful to develop a current resource list of the local community supports available specific to perinatal loss during my practicum. Thus, I contacted local agencies within the community and developed a Perinatal Bereavement Resource List (see Appendix D).

Besides not having sufficient time to do, providing follow-up to parents who lost custody of their child was not within the regular duties of the perinatal social worker at Orillia Soldiers' Memorial Hospital. For the most part, perinatal social workers cannot provide much support within the community. Instead they and the clients have to rely on community resources and supports. Although there are a number of local agencies that offer practical assistance and support in the way of shelter, income support, and generalized trauma and loss counselling to parents who lose custody of their children, no individual or group therapy or peer support groups are available specific for custody loss in the area. Given the limited bereavement related resources available to parents whose parental rights have been terminated, I developed an



informative package to give to parents and families in the event of a child apprehension. The package includes a bereavement related information sheet I created titled "Information You Might Want to Know Following a CAS Apprehension" (see Appendix E) and a copy of a downloadable booklet I found on-line called "What You Should Know About Child Protection Court Cases" (see [www.attorneygeneral.jus.gov.on.ca](http://www.attorneygeneral.jus.gov.on.ca)). In addition, I included in the package information on the signs and symptoms of Postpartum Depression and Mood Disorders.

### **Practice Challenges**

I found working within this particular social work setting to be both stimulating and rewarding. However, at times it proved to be emotionally and ethically challenging and discouraging. Each practice context has unique challenges that social workers have to find ways to overcome and/or deal with. This next section will discuss the two most prevalent practice challenges I encountered in my advanced practicum: professionals' personal biases and conflicted roles.

#### **Professionals' personal biases.**

The majority of the clients I worked with were socially disadvantaged. Many were of low socioeconomic status, lived in substandard housing and in rural areas, had a mental illness and/or intellectual disabilities. Also, a large percentage of these clients were young parents. In working with this population, I continuously had to be aware of, and evaluate, my own and others' negative judgments and attitudes about these clients' lifestyles. Furthermore, as McKegney (2003) pointed out, sometimes it is difficult to have empathy for parents whose children are taken into care. Importantly, though, by being cognizant and critical of how issues of class, race, and gender permeate child welfare, more enlightened and anti-oppressive understandings of custody loss can be developed. Personal biases are unhelpful and even harmful to families when



what they need most is understanding and compassion.

Although not the consensus among all professionals, I believed that the majority of the clients whose children were taken from their care were committed to their child's welfare but struggled in the face of poverty, substandard housing, violence, addiction, low education, lack of informal social supports, and limited community resources. As this advanced practicum report illustrates, discriminatory and biased assessments and interventions not only negatively impact clients' experiences and outcomes, but also act as a barrier to them seeking out supportive services. Additionally, in my work with these clients, I had to question whether or not my assessments and interventions were most appropriate given that they were culturally specific to white, middle class values. When working with social disadvantaged families, I looked beyond their individual situations and considered the wider social factors that affected their life circumstances, such as an eroded social welfare system, colonization, and discrimination and inequality based on race, class, gender, sexual orientation, and age.

Also related to this topic, as a feminist social worker, I recognized that power dynamics are inevitable in social work. Thus, I worked to reduce power imbalances in my practicum by advocating for client choice, as well as by promoting collaborative approaches among the clients and professionals, social work and medical professionals, and social work and child welfare authorities. Unchallenged biases can lead one to abuse their power and authority. For example, withholding information from clients when there are no contraindications, as well as providing misleading or false information is abuse of authority. I found taking the time to have important discussions with my supervisor and other professionals about clients' psychosocial-cultural realities generally helped to reestablish a sense of professional objectivity. Engaging in critical



self-reflection is crucial in practice because it helps prevent our professional assessments and decision-making from becoming tainted by unchallenged personal beliefs and emotions.

### **Conflicted roles.**

Social workers are expected to uphold numerous simultaneous and often conflicting agendas and mandates (McKegney, 2003). In this specific context, my duty to report child protection concerns conflicted with my professional obligation to support and advocate on behalf of the parents of those children. This was particularly challenging ethically because clients would trust and confide in me, yet some of the information they shared was reportable as a child protection issue. Explaining my duty to report would sometimes make it difficult to maintain a therapeutic relationship with families, thereby limiting my ability to provide bereavement related support following the apprehension. On occasion, it was obvious that clients were angry with me for involving CAS. In such instances, I acknowledged their feelings toward me, while reminding them of my mandate, as well as our responsibility as a society to protect the welfare of children. I emphasized my commitment to their success as parents and highlighted CAS's role in supporting and preserving families. Often shifting the focus of the child protection issue away from them as individuals and towards systemic issues was also helpful in these situations.

Most importantly, I had to learn to not personalize clients' anger and to accept that not every client was going to be open to my involvement. These practice situations emphasized to me more than anything else the utmost importance of being explicit with clients from the beginning about limits to confidentiality. In addition, whenever possible, allowing parents the option to contact CAS themselves or in collaboration with a social worker gave them some sense of control.

There were times when I was further challenged ethically because despite wanting to be



honest and upfront with clients about my obligation to make a report to CAS, I had to keep such information from them due to concerns about the parents' and families' responses, the safety of the environment, and other security risks, for example a flee risk. In my experience, clients' responses to my mandate to involve CAS was impacted by a number of factors, including my own and the CAS worker's approach, timing, the personality of the clients, and clients' past experiences with the child welfare system. Therefore, there never seemed to be a "good" time or a "best" way to go about informing families about CAS's involvement. McKegney (2003) pointed out, working in partnership with clients, while having the conflicting mandate of assessing for child protection concerns is a difficult task for even the most competent social workers. Overall, critical thinking, prioritizing, time management, and continuous consultation with the team were critical to my decision-making in these ethically difficult situations. By maintaining critical self-awareness, staying true to social work values, and by having realistic expectations of myself, I was able to successfully work through the context-specific challenges during my practicum experience.

In the next and final chapter of this practicum report I will conclude with a summary of what I learned from my advanced practicum experience and a discussion on what this knowledge could mean for my own and other's social work practice.



## Chapter 5 – Conclusion

As a society we place negative value on loss and the emotional responses associated with loss. Thus, so many of us find ourselves uneducated, ill-prepared and unwilling to deal with loss and grief (Seftel, 2006). Subsequently, too many individuals are left to grieve alone in isolation and silence. Loss is unavoidable because it is an inevitable process of having established roles and relationships in our lives (Zeman, 2005). Likewise, grief is a normal, healthy, healing, and loving response to the devastation of losing someone or something that is important to us. It is a tribute to who or what has been lost and entails remembering and reliving - a notion that challenges the common desire to avoid and/or get over loss and grief (Seftel, 2006). Although an inherent process in life, grieving a loss is a difficult process that nobody should have to go through alone. Therefore, we need to open ourselves up, especially as professionals, to learning about specific forms of loss and grief and the unique bereavement related support needs associated with such losses.

To fulfill part of the requirements for the Laurentian University M.S.W. program, I engaged in an Advanced Practicum (SWRK 6024R) from September 13, 2010 to November 30, 2010. The practicum setting was the Paediatric and Obstetric departments as well as the NICU of Orillia Soldiers' Memorial Hospital. My overall objective for completing an advanced practicum was to develop advanced clinical skills in social work intervention with individuals and families within a medical setting. More specifically, my training goal was to advance my knowledge and clinical skill in dealing with loss and bereavement with a focus on perinatal loss and bereavement. Unexpectedly, I also had the opportunity to explore infant custody loss. In this chapter, I will conclude by recapping what I learned from my practicum as it relates to perinatal loss and infant custody loss being two unrecognized forms of loss during the perinatal period,



and lastly by discussing social work implications.

### **Perinatal Loss and Infant Custody Loss: Two Unrecognized Forms of Loss**

Perinatal loss and infant custody loss are two very different, yet in some ways similar loss events. These two groups of bereaved parents not only share similar features in how they experience the loss and grief process, but also share loss experiences that have been historically under-acknowledged and undervalued. The literature indicated that both perinatal loss and custody loss continued to be socially unrecognized as significant losses and insufficiently addressed by professionals both in the research and clinical practice realms (Cacciatore, 2009b, 2010; Cacciatore & Bushfield, 2007; Cosgrove, 2004; Gold, 2007; Kenny & Druker, 2011; Kohn et al., 2000; Layne, 2006; Malacrida, 1999; McKegney, 2003; Novac et al., 2006; Pector, 2004; Price, 2008; Stratton & Lloyd, 2008; Raskin, 1992).

Consequently, I discussed the experience of perinatal loss and infant custody loss and in doing so emphasized the significance of these losses and the legitimacy of the parents' grief responses. Additionally, in an attempt to better meet clients' bereavement support needs following these two loss events, I utilized a feminist-informed social work practice approach that incorporated ecological, systems, strength-based, holistic, and collaborative approaches. My practice approach also made an effort to ensure clients' dignity was maintained and that their right to choice was respected, thereby promoting anti-oppressive practice.

More specifically, my practicum experience revealed that there have been improvements made in the way perinatal loss is perceived and supported by helping and health professionals. At the same time, however, there continues to be a need for more bereavement services to meet the needs of families following a perinatal loss in the Orillia and surrounding area. This includes a need for individual counseling, group therapy, and support groups both within and outside of the



hospital setting. Furthermore, my practicum experience helped me uncover prevailing oppressive structures and notions that disregard parents' experiences of infant custody loss which in turn leaves them with little or no emotional support. I identified in my practicum setting an even greater need for improved and expanded bereavement services for parents and families experiencing the devastating loss of infant custody. The value of having established procedures for supporting bereaved families through both perinatal loss and custody loss is clear given the striking difference in how these two loss events were handled in the absence of an infant/child apprehension policy that considered parents' support needs.

To help address some of these identified needs during my practicum I developed bereavement related materials as described in the previous Chapter of this report. Further contributing to the funding constraints, which limit the support available to these client populations, there remain pervasive societal judgments and expectations of parenting, particularly mothering norms that contribute to the lack of understanding and support for those who experience custody loss. Biased and discriminatory notions need to be replaced with realizations of how issues of class, race, and gender affect individuals' lives, particularly the lives of women. Moreover, we must be mindful of the intrusive and adversarial nature of child welfare involvement in one's life. Agencies and professionals alike must ensure that their obligation to prioritize child welfare does not undermine their efforts to support and advocate on behalf of the parents. Overall, instead of viewing one form of loss as more or less severe than another form of loss, professionals involved in providing care and service to families who experience either a perinatal or infant custody loss must recognize the magnitude of these loss experiences from the clients' perspectives. Regardless of the cause or form, any individual client grieving the loss of a child is entitled to compassionate and comprehensive bereavement support.



## Social Work Implications

This research focus was derived from insight gained from both the literature on perinatal loss and custody loss, as well as from needs identified in my practice. The perinatal loss and custody loss literature indicates that there are various needs for further research on these topics. For instance, Cosgrove (2004) identified a need for perinatal loss research that reflects the voices of non-heterosexual couples. Likewise, Kenny and Druker (2011), McKegney (2003), and Novac et al. (2006) indicated that there is limited research that explores birthparents' experience of custody loss. Furthermore, there is a need for research that evaluates specific interventions post-pregnancy loss (Cacciatore & Bushfield, 2007; DiMarco et al., 2001; Gerber-Epstein et al., 2009; Rich, 2000; Stratton & Lloyd, 2008), as well as post-custody loss (Novac et al., 2006).

Likewise, my advanced practice experience emphasized the need for improvements in bereavement support offered to families who experienced either a perinatal loss or infant custody loss event. The lack of social validation for the significance of these loss events can have and, as this report has illustrated, has had long-term physical, psychological and social effects on mothers, fathers, and families. Therefore, as social workers and as a society as a whole we must recognize the significance of the tragic loss of a child whether as a result of a perinatal loss or a custody loss. Social workers can encounter clients who have suffered from either one of these two devastating forms of loss in any social work setting. Thus, in addition to working to better support these bereaved families in the hospital setting, we should work to also bring awareness to the experience and services needs of these two client populations in other social work settings, including in our respective communities.

Although there is emphasis on the importance of acknowledging the effect perinatal loss and custody loss has on the entire family, especially on fathers whose emotional responses to



loss are often underestimated, it is essential to recognize that these loss experiences affect women's lives in unique ways. Additionally, because these two loss events have been oppressed experiences particularly impacting the lives of women, a feminist social work approach is invaluable in working with these client populations. In fact, I am concerned that without a feminist understanding and approach to this work that pervasive beliefs and values that resulted in the historical oppression of these loss experiences will be perpetuated. Consequently, these bereaved families will continue to be left to grieve in isolation.

Given the emotional state after these loss events, bereaved parents are not likely to make requests for the bereavement services and care they require. Therefore, if not offered, they generally will not receive the support they need (Kohn et al., 2000). Furthermore, when clients are socially isolated and experiencing disenfranchised grief they tend to believe that they do not have a right to their feelings which in turn prevents them from asking for help (Bentz & Thomgren, 2006).

Social work is inherently intrusive. We become involved in the very private aspects of individuals' lives and family affairs, sometimes even when not requested or desired by the clients. It is especially important to be mindful and sensitive to the fact that child protection involvement is perceived as an invasion of privacy, and is often a humiliating and belittling experience. However, at the same time, respect for individuals' privacy after a perinatal loss or custody loss cannot be used as an excuse to avoid dealing with these difficult loss experiences. Avoidance can no longer serve to reinforce the invisibility of both perinatal and custody loss events. As social workers we must delicately balance respecting individuals' need for privacy following a loss with their need for attention and recognition for their loss and grief (Hinton, 1999). It is the hospital and its staffs' responsibility to ensure that protocols for loss related



is further necessary training in assessment and intervention strategies and that appropriate assessment and intervention strategies are provided to ensure that clients are provided with assessment and intervention strategies and that they are able to use them in their practice. (Klein et al., 2000). More specifically, hospital, health and social service agencies need to ensure that they have appropriate policies and procedures in place to ensure that they are able to use them in their practice and that they are able to use them in their practice. (Klein et al., 2000). More specifically, hospital, health and social service agencies need to ensure that they have appropriate policies and procedures in place to ensure that they are able to use them in their practice and that they are able to use them in their practice.

Furthermore, there is a need for more specialized assessment support for those who have experienced a personal loss or a custody loss. Despite funding constraints, personal social workers, especially those in smaller cities and communities, need to strongly advocate that funding be allocated towards their program's assessment services for things such as assessment support, group therapy, and training opportunities. An innovative way to improve the quality of assessment services is to encourage students who complete placements within the hospital to take on funding projects and to support bereaved parents who are interested in the same. Additionally, working with other professionals who work with children, such as psychologists, social workers, and family therapists, can help to ensure that the best possible outcomes are achieved for all involved. For instance, during my placement I worked with two bereaved mothers who are the founders of the only personal loss peer support group currently available in the geographic area surrounding CHCH. Additionally, at a conference in Toronto, I met a social worker who co-developed and facilitated a Crisis and Loss Education and Action Group in Toronto for women who have had their children approached by C.A.S. At the same conference, I also met a personal social worker who shared with me her extensive experience with infant apprehensions from working at St. Michael's Hospital in Toronto. Having awareness of the assessment support provided at hospitals and the role of professionals in the assessment process is crucial to ensure that the best possible outcomes are achieved for all involved.



practice and contexts.

Social workers' interactions with bereaved parents can have a profound effect on the outcome of their loss experience, as well as their recovery and long-term wellbeing. Because hospitals are one of the first lines of contact women and families have with service providers in the event of a perinatal loss or custody loss of a newborn, hospital social workers are in an ideal position to provide immediate bereavement support and guidance to these parents and their families. Social workers, especially those in hospitals, are in a position to become actively involved in reaching out to women and families to help them express their voices after the loss of a baby. With adequate bereavement training and organizational support, perinatal social workers have the opportunity to prevent these women and their families from re-experiencing memories of being treated unkindly by professionals or having later regrets following these loss events.

Although beyond the scope of this report, it is important to point out that there is a need for policy makers' attention and government funding for wider social services that impact the lives of these bereaved families. As already mentioned, studies are highly suggestive that conditions of child "neglect" are more often the effect of poverty rather than a malicious intent on the behalf of parents to harm their children. These socially disadvantaged parents are expected to provide adequate parenting with minimal support from a badly eroded social welfare system (Novac et al., 2006). Clearly, policy changes in income security are required to enable parents to provide for their children as socially expected of them.

Additionally, the CAS is in dire needs of government funding in order to promote family preservation, worker support, and quality assurance of foster and group homes (McKegney, 2003). Furthermore, to better address parents' support needs following an apprehension, addiction programs, transitional homes, shelter staff, and other community counseling and



treatment programs should also be trained and prepared to appreciate and address the impact of involuntary loss of custody. Likewise, one of the most commonly reported needs made by these clients is for parenting groups, specifically for those with children living in foster care.

Additionally, there is a need for more supervised living environments as they are one of the most important resources for preventing apprehensions and promoting parent-child unification (Novac et al., 2006). Lastly, social workers in any practice setting can help clients facing probable custody loss by emotionally supporting and preparing them in the prenatal period for the possibility of an apprehension and strongly encouraging them to contact CAS for prenatal support.

Given the emotional toll working with clients experiencing the loss of a child has on the professionals working in this area, it is critically important that social workers access on-going professional support and supervision. Supervision is invaluable because it aids in developing and sustaining professional standards and values, it works to prevent harm to clients, provides support to practitioners thereby preventing burnout, and fosters reflective practice and professional development. However, a challenge and frustrating reality for social workers is their lack of access to supervision. Practitioners and managers are pressured to do more for less. Thus, there are fewer opportunities for formal supervision and professional development.

Consequently, practitioners are left feeling unsupported and discouraged with little opportunity to gain new insight and knowledge. In addition to respectfully placing pressure on our managers for access to quality supervision, we can seek out creative and alternative modes of supervision. For instance, having formal and informal individual or group discussions with colleagues about practice dilemmas and/or paying for professional supervision can act as vital sources of supervision (Noble & Irwin, 2009).



All in all, despite the emotional nature of this work and the practice challenges related to providing support to families who have suffered perinatal loss or infant custody loss, it is nonetheless very important and rewarding work because it involves being present and supportive at a time when people most need unconditional emotional support. Being present is the ultimate gift you can give someone who is grieving a loss. Avoiding painful loss topics and making attempts to take away individuals' pain is not helpful instead it is hurtful, even harmful. Grieving and healing is not about moving on and putting the loss behind us but rather, healthy grieving involves incorporating the lost loved one into one's life in a way that does not interfere with the ability to live in the here and now (Seftel, 2006).

In any loss situation, as social workers we can support clients through their loss and grief by first demonstrating a willingness to be present with them and open to listen to their stories of loss. This could involve just sitting beside them in silence, or listening to them without any judgment or agenda. By validating their loss experience as significant and their emotional responses as legitimate we offer bereaved individuals an opportunity to begin to deal with, and heal from their loss. Importantly, both our words and actions must demonstrate our recognition for the depth and complexity of their emotions. This involves truly taking the time required to understand each client's loss experience from their own unique perspective, what their loss means to them as a whole, and offering holistic bereavement support accordingly. As social workers we need to recognize that what is most important when working with loss and bereavement is that loss is uniquely significant to each individual's experience of it; therefore, we must approach each loss experience with the same consideration as the next.

Through my advanced practicum experience, I have developed advanced knowledge and skill in bereavement intervention specific to perinatal loss and infant custody loss. This newly



gained knowledge and practice experience has taught me how to accept and better manage my own discomfort with loss and bereavement. To get to this point, I had to realize that it is in fact normal and acceptable to feel some discomfort in situations of loss. I feel more emotionally available to be present with people and to embrace their intense emotional responses to loss as well as my own.



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## Appendix A

### Perinatal Loss Policy & Perinatal Bereavement Checklist

ORILLIA SOLDIERS' MEMORIAL HOSPITAL  
Manual – Policy/Procedure

NUMBER: IV-d-465 Nursing

DATE: January 2011 - R

<b>Issued By:</b>	BANFS
<b>Committee Reference(s):</b>	Obstetrics Care Team
<b>Title</b>	Care of Family and Infant During and After Neonatal Death or Stillbirth

- |                              |  |
|------------------------------|--|
| Definitions                  | <ol style="list-style-type: none"> <li>1. To provide medical and emotional support during the loss of a child.</li> <li>2. To plan and set objectives, strategies and/or interventions in consultation with the patient, her family and the medical staff.</li> <li>3. To implement the plan in a manner which will encourage the patient and her family circle to participate in her care.</li> </ol>   |
| Goals for care               | <ol style="list-style-type: none"> <li>1. When possible, support the desires and wishes of the family throughout the process.</li> <li>2. Provide a place and opportunity for the family to labour, deliver and grieve in private.</li> <li>3. Obtain and follow the perinatal bereavement checklist.</li> <li>4. Prepare the white eyelet grief package of baby's belongings for the parents.</li> <li>5. Obtain the proper administrative/government forms and process them according to their guidelines.</li> <li>6. Give gestation appropriate packages to inform patient and her family about support services, grief counselling and management of subsequent pregnancies.</li> </ol> |
| Procedure CARE OF THE MOTHER | <ol style="list-style-type: none"> <li>1. For <b>known intrauterine deaths</b> give the patient and her family factual information about what will happen to her and the baby before the patient goes into labour. Provide booklet with age appropriate pictures of baby so patient and her family can prepare and ask questions about the baby</li> <li>2. Allow the patient and her family time to comprehend what they will experience and to grieve for their baby prior to inducing labour.</li> <li>3. Allow the patient to be as pain free in labour as medically possible.</li> </ol>  |



4. For **high risk neonates**, keep patient and her family informed and involved with the baby's care as much as possible.
5. Medically and emotionally support the patient and her family.
6. Provide coping tools and support systems to help deal with the infant's death.
7. Provide the standard postpartum comfort measures after delivery.
8. Follow up with a note to the patient and her family two to four weeks post discharge.

#### Procedure – CARE OF THE BABY

1. Send placenta in formalin and requisition to Pathology.
2. Physician to contact Coroner if requirements apply.
3. Obtain cord blood, if able, when Mom is Rh negative.
4. Obtain 3 cc of blood from baby if chromosome study required and send to hospital lab. If unable to obtain blood sample, take a section of baby's cord, cover with normal saline and send to pathology.
5. Apply cord clamp to cord.
6. Give parents the opportunity to hold baby and to do as much of baby's care as they wish.
7. Do not remove any tubes from baby if there is to be an autopsy.
8. When parents allow you to take baby, give the parent(s) the option to participate:
  - Cleanse baby body as necessary
  - Weigh and measure baby
  - Record information for chart and parents
  - Dress baby in an appropriate outfit
  - Have a baptismal, prayer service and/or remembrance ceremony according to parents wishes
  - Give parents the option of bathing and/or dressing baby
  - Baby face cloth and soap can be supplied if available.
9. Within eyelet cover:
  - Baby's foot and hand prints
  - Digital pictures with hospital camera, picture printer in Social Worker office.
  - Hair comb
  - Measuring tape



- Outline drawing of baby
  - Seashell used in baptismal or prayer
  - The baby's bands and crib card
  - Knitted sweater, bonnet and bootie set with blanket left with baby or given to family
  - Size appropriate gown
  - If able, obtain a lock of hair
  - Abdominal staples if patient a Caesarean section
10. Allow parent and their family as much grief time as they direct, with baby.
11. When decision made by the parents to let baby go:
- Attach identification to baby
  - Wrap baby or dress baby in suitable clothing
  - Attach identification of baby to inside and outside of blanket
  - As security or transfer baby, wrapped in a visibly labeled blanket to morgue.
12. Stillbirths should be reported to the Coroner's Office only if they meet the criteria in Policy #IV-d-465.
13. If an autopsy is requested by the parent or if medically indicated an authorization form for the autopsy needs to be signed by the parents.
- Documentation
1. Provide physicians with proper forms to complete. Guideline of forms listed in Policy #IV-d-470.
  2. Provide parents with the appropriate forms to fill out and give them mementos of their child.
  3. Record nursing assessments and information in appropriate places. Obtain any forms required and send to relevant places.
  4. Social worker or designate will initiate phone call or visit during the patient's hospital stay.
  5. Sympathy card from staff will be sent in 2 to 3 weeks after patient goes home.
  6. Individual nurses involved may send card or make a phone call is appropriate and desired.
  7. Social worker or designate will send card on 1 year anniversary of baby's birth/death.





**ORILLIA SOLDIERS' MEMORIAL HOSPITAL**  
**PERINATAL BEREAVEMENT CHECKLIST**

Please use sticker with patient's address

**Demographic Information**

Mother's Name: \_\_\_\_\_

Partner's Name: \_\_\_\_\_

Support People/Person: \_\_\_\_\_

Para \_\_\_\_\_ Gravida \_\_\_\_\_ EDC \_\_\_\_\_ Gestation \_\_\_\_\_

Sex Of Baby \_\_\_\_\_ Baby's Name: \_\_\_\_\_

Weight \_\_\_\_\_

Date of delivery (yyyy/mm/dd) \_\_\_\_\_ Time \_\_\_\_\_

☐ Miscarriage (< 20 weeks)

☐ Stillborn ( $\geq$  20 weeks)

☐ Neonatal Death (> 20 weeks, where there is breathing, beating of the heart, pulsation of umbilical cord or movement of voluntary muscle)

Induction ☐ Yes ☐ No Reason: \_\_\_\_\_

Nurses involved: \_\_\_\_\_



Doctors involved:

Plan of Care
1. Discussed anticipated course of pregnancy, labour and delivery including pain control with: <div><input type="checkbox"/> Mother    <input type="checkbox"/> Father    <input type="checkbox"/> Other</div>
2. Discussed possible appearance of baby: <div><input type="checkbox"/> Mother    <input type="checkbox"/> Father    <input type="checkbox"/> Other</div>
3. Discussed amount of personal care the parents want to do for the baby: <div><input type="checkbox"/> Mother    <input type="checkbox"/> Father    <input type="checkbox"/> Other</div>
4. Neonatal prognosis of infant discussed by: <div>Obstetrician    Physician    Pediatrician</div>
5. Parents notified of fetal demise: Date    Time
6. Physician has pronounced time of death: Date    Time
7. Saw baby when born, or at time of death: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other



8. Touched or held baby: ☐ Mother ☐ Father ☐ Other \_\_\_\_\_

9. Offered private time with baby: ☐ Yes ☐ Declined ☐ Deferred

10. Baby named: \_\_\_\_\_ Gender: \_\_\_\_\_

11. Special Ceremony: ☐ Baptism ☐ Prayer Service ☐ Other \_\_\_\_\_

Performed by: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

12. Parents informed of need for funeral arrangements: ☐ Yes ☐ No ☐ N/A (miscarriage)

### Plan of Care

13. Funeral Home has been contacted by parent or family members: ☐ Yes ☐ No ☐ N/A (miscarriage)

Name of Funeral Home and phone number: \_\_\_\_\_

14. Parent have given consent for mementos to be gathered: ☐ Yes ☐ No

Photographs taken: ☐ Yes, by: \_\_\_\_\_

☐ No, reason: \_\_\_\_\_

Photographs given to parents: ☐ Yes ☐ Declined ☐ Deferred

Foot/hand prints done: ☐ Yes, by: \_\_\_\_\_

☐ No, reason: \_\_\_\_\_

Lock of hair gathered: ☐ Yes, by: \_\_\_\_\_

☐ No, reason: \_\_\_\_\_



Teddy bear given: ☐ Yes ☐ No

15. Parents given baby's Memorial Package, including white eyelet cover with memorabilia, completed memory book with keepsakes and white information folder.

☐ Yes ☐ No, reason: \_\_\_\_\_ ☐ N/A  
(miscarriage)

16. Unrecognized Pregnancy: ☐ Yes ☐ No

Memorabilia, pictures placed in brown envelope and sent to medical records ☐ Yes ☐ No

Parents given Information Folder with Social Worker's name and telephone number ☐ Yes ☐ No

17. Provide education for family members and friends with pamphlets specific for them.

18. Summary of forms completed, please check off which form is being completed:

**Under 20 weeks (Miscarriages)**

- ☐ **Letter of Compassion from the attending Physician is required.**
- ☐ The disposition of the remains to a cemetery or crematorium is subject to the parents' request.

**20 weeks – 40 weeks (Live Birth)**

- ☐ Notice of Live Birth or Stillbirth (Form **1**) from hospital.
- ☐ Medical Certificate of Death (Form **16**) from hospital
- ☐ Statement of Live Birth (Form **2**) required from parents.
- Statement of Death (Form **15**) - provided by funeral home to parents

**20 weeks – 40 weeks (Stillbirth)**

- ☐ Notice of Live Birth or Stillbirth (Form **1**) from hospital.
- ☐ Medical Certificate of Stillbirth (Form **8**) from hospital
- ☐ Statement of Death (Form **7**) from hospital.

Refer to policy, or outside of file box with forms in Bereavement cupboard for directions on completion/direction.



19. Autopsy: ☐ Yes ☐ No

20. Social Worker notified: Date \_\_\_\_\_ Time \_\_\_\_\_

21. Resources in the community explained to family: ☐ Yes ☐ No

22. Follow-up Bereavement Information sheet completed and put into small black binder ☐

### Follow Up

Bereavement card sent by staff in 2 – 3 weeks: ☐ Yes ☐ No Reason: \_\_\_\_\_

Date sent \_\_\_\_\_

Social worker made initial contact with patient, while patient is in hospital: ☐ Yes ☐ No

Reason: \_\_\_\_\_ Date/time of follow up: \_\_\_\_\_

Card sent by Social Worker on First Anniversary of Baby's delivery

Date sent \_\_\_\_\_



## Appendix B

### Apprehension of Infant/Child Policy

ORILLIA SOLDIERS' MEMORIAL HOSPITAL  
Nursing Manual – Policy/Procedure

NUMBER: xxx  
DATE: Oct/ 1989 – 0  
Feb/ 04 – R  
April/ 09 - R

*Issued By:*

*Committee Reference(s):* Neonatal/Paediatric Care Team

**Title** Apprehension of Infant/Child by the Children's Aid Society  
Paediatrics/Neonatal/Outpatient Clinic

**Policy Statement** To provide a place of safety for the child.

1. A police officer or a C.A.S. staff member has the authority to apprehend the child and designate a place of safety.
2. A child may be apprehended if child abuse or neglect is suspected.

**Personnel Who** Nursing Staff &/or Administration

**May Perform** Security Personnel

Physician

Social Worker

- Procedure**
1. Once contact is made with C.A.S., the Health care professional must ask if the child is at high risk for apprehension, and if violent behaviour is noted with care provider. If C.A.S. discloses that the child is at high risk for either, inform the Paediatrician, and ask Security to remain on stand-by.
  2. Notice of intent to apprehend will be given to Health Care



Professional. This may be given by telephone, but must be followed by the C.A.S. formal notice of apprehension, which designates the Hospital as a place of safety.

3. C.A.S. will provide Authorization to detain child in hospital as a place of safety. Append Notice of Apprehension to the health record. Notice valid for 5 days including day of apprehension. On day five there will be a change in legal status which will determine who is responsible for the child as confirmed by C.A.S.
4. If parents, guardian or relative insist on removing child from the hospital, immediately notify:
  - a) Security
  - b) Police
  - c) Nursing Administration/Manager (Supervisor after hours)
  - d) Most Responsible Physician
  - e) C.A.S. (If not present)
5. The child is discharged only on the Physician's order and only to the care of the C.A.S. worker. The C.A.S. worker must show agency photo identification.
6. C.A.S. will provide "Authorization to Discharge Child from Hospital"

Patient Teaching      Not applicable

Documentation      

1. Append "notice of Apprehension" to the health record.
2. If C.A.S. continues to be responsible for the child then a further written directive must be provided and placed on health record.
3. Document apprehension in patient progress notes

References      Children's Aid Society. *Child & Family Services Act. (CCFSA Section 72)*.  
 Neonatal/Paediatric Care Team  
 Regional Sexual Assault & Domestic Violence Program



## Appendix C

### Apprehension Consideration Checklist

#### CAS APPREHENSION CHECKLIST

The following list was prepared in order to assist staff who may be managing a CAS apprehension of a baby or child in the Maternal Child and Youth Program.

Notification of apprehension may occur in writing, on the phone, or in person by a CAS worker. If the child is to be maintained in a place of safety such as the hospital, CAS is asked to provide written documentation for our hospital records although CAS is not required by law to do so. Consents must be on file for CAS to share detailed information with OSMH. The reason for apprehension is confidential, although often we are aware of concerns, or may in fact have initiated contact with CAS.

At the moment of apprehension CAS gains custody of the baby/child and is responsible for any consent for the baby/child. CAS may inform us of their intention to apprehend prior to the official apprehension. **When possible we would like to be prepared for the moment when CAS notifies the family so that we may notify security, find a safe place for the baby/child, find a safe and private room for discussion between CAS and parents, and notify all appropriate staff.**

#### NOTICE OF APPREHENSION (ACTUAL OR INTENDED)

☐ CAS has informed us about apprehension

#### Reason for Apprehension

☐ If known, CAS disclosure of reasons for apprehension is documented (CAS not required to disclose by law).

**Use a team approach.** Ensure the following are notified:

☐ Social worker (This person will take a leadership role during M-F work hours.)

☐ Ward clerk

☐ Nurse in charge



- ☐ Nurse(s) most responsible for baby /child
- ☐ Nurse(s) most responsible for mother (if she's a patient)
- ☐ Most responsible family physician / paediatrician for baby
- ☐ Most responsible family physician / obstetrician for mother
- ☐ Security(x3272 or via switchboard)
- ☐ Discuss possible need for police with CAS and OSMH security. OPP is likely to be contacted when there is any threat of violence or flight.
- ☐ Crisis worker x3536 **if** there is a documented history of serious mental health issues with one or both parents; request they be on standby.

### **Parent Knowledge of Apprehension**

**Parents NOT aware of apprehension – disclosure to be made by CAS ONLY**

- ☐ Parent(s) aware of plan to apprehend
- ☐ Notification of apprehension occurred outside of OSMH
- OR** ☐ Notification of apprehension to occur at OSMH (Ensure steps are followed as listed below.)

### **Documentation of Apprehension**

Letter from CAS is placed

- ☐ in the baby / child's medical record, and documented in the care plan
- ☐ in the mother's medical record (if she's a patient), and documented in her care plan.

**OR** If notification occurs by phone or in person, documentation regarding notification of apprehension must include who was informed, by whom, date and time, and be placed

- ☐ in the baby / child's chart and on the care plan.



☐ in the mother's medical record (if she's a patient) and on her care plan.

For OBS: It is often helpful if the most responsible physician (family doctor or obstetrician) discharges the mother prior to or as soon after notification of apprehension if medically indicated.

☐ Mother on OBS is not ready for discharge.

☐ Mother on OBS has a discharge order.

### ACCESS TO A HOSPITALIZED BABY/CHILD IN THE CUSTODY OF CAS

All consents of a baby or child in the care of CAS must be signed by them. Parent access and involvement will be determined by CAS. CAS in collaboration with OSMH staff will decide if the baby can remain with the parent(s) in exceptional circumstances, or if newborn, will be cared for in the nursery. **When unknown the baby/child will go to the nursery and/or be monitored by staff until further direction is received from CAS.** CAS may authorize access of other family members, or caregivers, and should do so in writing. If supervision of the parent(s) is required CAS or delegate will be required to provide this supervision.

CAS will provide a caregiver for the 48 hour care period (if required); this person's name will be in writing from CAS; this person must present ID upon arrival.

Clear guidelines from CAS include:

☐ Parent access clarified.

Specify: ☐ Parent(s) allowed full access

☐ Baby/child to be removed from parents; parents may have visits without CAS

☐ Baby/child to be removed from parents; parent(s) must have scheduled, supervised visits only.

☐ Parent(s) may not have access.

☐ Other: \_\_\_\_\_



☐ Visitor(s) allowed include: \_\_\_\_\_

☐ Breastfeeding or supplying of breastmilk

☐ Discharge plan for baby/ child

☐ Staff is aware of CAS direction and this is documented on the baby/child's medical record, including the care plan.

### **DISCHARGE OF BABY/CHILD UNDER THE CARE OF CHILDREN'S AID**

☐ Family Physician/paediatrician has written a discharge order for the baby/child

☐ CAS worker (or designate for discharge) has presented ID, and this is documented. If the CAS designate is a foster parent, written notification by CAS must include complete name of the intended foster parent(s).

☐ Nurse performs a head to toe discharge assessment in presence of CAS or designate.

☐ Baby's health card is given to CAS or designate (1<sup>st</sup> application) (Note: Some CAS offices will reapply for a new health card when they take a child into care.)

### **FAMILY SUPPORT**

☐ The social worker was present when CAS informed family of apprehension.

☐ OSMH social worker and nurses provided family with emotional support following apprehension.

☐ At discharge OSMH staff and CAS provided choice to parents when appropriate, ie. to see baby/child, to say good-bye, to dress the baby/child for departure, to send items with baby-child, to take hospital mementos (crib card, ID bands) to walk child to CAS vehicle.

☐ Family has received "Information You Might Want to Know Following a CAS Apprehension"



☐ Family has received "What You Should Know About Child Protection Court Cases"

Other: \_\_\_\_\_



## Appendix D

### Perinatal Bereavement Resource List

#### Perinatal Bereavement Resources in Orillia

##### BandB Journey of Hope Support Group

Co-founders: Kristin Vanderstelt & Charmayne Hollis

BandBJourneyofHope@gmail.com

- A support group geared at being the hub for resources and support for grieving, bereaved parents of pregnancy or infant loss. Offers support and education to families, hospitals, nurses and other health professionals about how to help bereaved families.

##### Perinatal Bereavement Support Ontario

(905) 472-1807 or www.pbso.ca

- There is a support group and an annual candle lighting service located in Barrie. Parents can join the groups at any time by calling the PBSO office to register. Groups generally run in the evenings welcoming both mothers and fathers, alone or as a couple. There is no charge for this service.

##### Orillia Native Women's Group

(705)329-7755

- Offers loss and grief support, counseling and workshops. You do not have to be Native or female to access services.

##### Catholic Family Services of Simcoe County

(705) 726-2503 or 1-888-726-2503



## Appendix D

### Perinatal Bereavement Resource List

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##### **Catholic Family Services of Simcoe County**

(705) 726-2503 or 1-888-726-2503

- Individual, couple and family counseling. Service is available to anyone in need, regardless of religious affiliation. Service is provided on a sliding fee scale. Subsidies are available for those who qualify. Appropriate for those experiencing issues such as: family conflict, stress, *grief, depression & anxiety*, relationship issues, separation & divorce and abuse. You can call to inquire about making an appointment or go to the Orillia or Barrie walk-in counseling clinic which operates on a first-come first-serve basis.
- **Orillia** -open every 2nd and 4th Monday of each month from 1:30 p.m. to 5:30 p.m.  
**Location:** St. Joseph House 24 Penetang Street (on the grounds of Guardian Angel Catholic Church) in Orillia
- **Barrie** – open every Wednesday 1pm-7:30 pm and every 1<sup>st</sup> and 3<sup>rd</sup> Monday from 1pm-7:30pm. **Location:** 20 Bell Farm Rd, Unit 5



### Additional Bereavement Internet Resources

- Bereaved Families of Ontario.....[www.bereavedfamilies.net](http://www.bereavedfamilies.net)
- The Compassionate Friends of Canada.....[www.tcfcanada.net](http://www.tcfcanada.net)
- First Candle.....[www.firstcandle.org](http://www.firstcandle.org)  
1-800-221-7437 Grief Counsellors Available 24/7
- Now I Lay Me Down to Sleep.....[www.nowilaymedowntosleep.org](http://www.nowilaymedowntosleep.org)
- Centering Corporation- Grief Resource Centre.....[www.centering.org](http://www.centering.org)

Some hospice organizations and funeral homes offer bereavement support.

You may also want to look into your Employee Assistance Program (EAP) for individual or couple support through your place of employment.



## Appendix E

### Bereavement Related Information Sheet

#### **Information You Might Want to Know Following a CAS Apprehension**

*A quote by a mother who had her child apprehended by CAS:*

*"It's a huge loss. It's grief. It's trauma. It's loneliness...It's everything.  
It affects you in every way imaginable—emotionally, physically, spiritually.  
It feels like part of you is missing. You can't eat, you can't sleep.  
It changes your health. It changes everything about who you are"*

You may experience trauma and grief as a result of having your child apprehended by CAS. We want you to know that we recognize that you are a parent whose experience of loss needs to be recognized.

#### **How You Might Feel**

Grief is a normal and beneficial response following the loss of custody. Often with loss parents experience denial, shock, disbelief, numbness, sadness, and guilt. Feeling uncertain and confused are not uncommon. Other parents have reported feeling worthless, humiliated, betrayed, angry and desperate to understand *why* this is happening and *what* you can do to change it. Because the loss of a child is traumatic, it can trigger past loss experiences and other traumas.

In the post-partum period you may experience mood fluctuations as a result of hormonal changes. You may also feel tired and sore from giving birth. Your breasts might be tender and may fill with milk. These physical changes may make your experience of loss more difficult. Your post-partum discharge instructions and the Postpartum Depression information sheet may answer any additional questions you may have.

#### **Ways You Might Cope**

You might be tempted to cope in unhealthy or self destructive ways i.e. self-medication with drugs and alcohol, anger and violence, and/or having more children.

#### **There are more constructive ways to cope such as:**

- talking to family and friends
- seeking support from professionals i.e. counselors, religious and spiritual advisors
- journal, paint, use other creative arts
- try to focus on the future, not the past. What can you do to get your baby back in your care? (Make a Plan.)



- if you need urgent physical or emotional care and support call you family doctor, go to your nearest walk-in-clinic or emergency room
- refer to "What You Should Know About Child Protection Court Cases" for information to help you through the court process with CAS

## **Below are community resources you might find helpful:**

### **MEDICAL CARE**

Orillia After Hours Medical Clinic.....327-0578  
 Orillia Soldiers' Memorial Hospital.....www.osmh.on.ca 325-2201  
 Telehealth – 24 hour health information line, talk with a registered nurse .....1-866-797-0000  
 Telecare Orillia – 24 hour distress line, anonymous and confidential .....325-9534

### **FINANCIAL & EMPLOYMENT**

County of Simcoe .....www.simcoe.ca 722-3132  
 • Ontario Works – provides financial and employment assistance to people in temporary financial need ..... press 3  
 • Social Housing – assistance for subsidized housing for low to moderate income families..... press 5

### **SHELTERS & TRANSITIONAL HOUSING**

Couchiching Jubilee House.....www.shelternet.ca 326-4337  
 Green Haven – outreach services and shelter for abused women and children ..... 327-7319  
 Athena's Sexual Assault Counselling and Advocacy Centre.....737-2008 or 1-800-987-0799  
 Elizabeth Fry Society – transitional housing for women for a max of 60 days (Barrie).....705-725-0613  
 Samaritan House– transitional housing, provides counseling and educational programs (Barrie).....705-720-7111

### **ADDICTION SERVICES**

Centre for Addiction and Mental Health - information, referral, or support regarding drugs or mental health .....416-535-8501(x6111)  
 Simcoe County Addiction and Mental Health Services: Umbrellas Program –support, treatment and referral related to substance use, for prenatal and postnatal women (other programs also available).....325-4499 (x 103)  
 Barrie Detox Centre.....705-728-4226

### **CRISIS SERVICES**

Mental Health Crisis Line & Mobile Crisis Response-- assessment, counselling and referral .....1-888-893-8333

### **COUNSELLING**

Legal Aid.....1888-590-3961 or 737-3400  
 Orillia Native Women's Group – information, support & services for families. You do not have to be Native or female to access services .....329-7755  
 Catholic Family Services– counseling available to anyone in need, regardless of religious affiliation. 705-726-2503 or 1-888-726-2503

### **OTHER**

The Sharing Place – Food Bank .....327-4273  
 211 Simcoe County – information on community, health, social and government services..... www.211simcoecounty.ca or dial 211  
 Simcoe County Children's Aid Society – information, support & services to protect children and strengthen families.....325-1005